Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month 2000 10:51 AM January 1, Gussie Lubitz 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplaca (State or Foreign Country) New York 8. Data of Birth (Month, Day, Year) Days 1 M 200F Months Hours 82 136-34-7139 Sep. 30, 1917 Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 14 Yes 2 □ No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20852 6121 Montrose Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Boy Scouts of America Secretary 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Frieda Mendelson Jacob Kreisman 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Copper Beach Circle, White Plains, NY 10605 Murry Lubitz/ Son 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata Jan. 3, 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from Stata Menorah Gardens 4 ☐ Donation 5 ☐ Othar (Specify) West Palm Beach, FL 2000 21. Signature of Funaral Service License 22. Nama end Addrass of Fecility Danzansky-Goldberg Memorial Chapels. Inc. 1170 Rockville Pike, Rockville, MD 20852 tottle 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Onset and Deeth · Chronic Obstructive Pulmonary Immediata Causa (Finel diseasa or condition resulting in death) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Sclerosis 1 | Yes 2 | No 3 | Probably 4 | Onknown Multiple 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury

In 0 physician and s the burishirans 0 Records, -ubitz ž # Division 1991e

or Attend after death Director: Funeral

Physician/Medical P Completed Be 10 Certification:

Physician

Examiner

Funeral

Director

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Insportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examiner must be notified at an and be notified at an and the standard.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

5

the Maryland

/Medical

Directo

Funeral

þ

Completed

Be

2

MD

Vother P

1 Yes 2 No 27. Manner of Death

(Check only one)

2 Accident 3 ☐ Suicida 4 ☐ Homicida

6 ☐ Could not be

28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 11D Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and fitla of certifier

29c. License number D53244

29d. Date signed (Month, Day, Year) January

30. Nama end eddress of person who completed cause of death (Hem 23a) (Type, Print) Kathari'ne R. Li'lli'e, MD, 11140 Rock Katharine

Rockville Pike#348, Rockville, MD 20852

State Registrar

31. Data filed (Month, Day, Year) JAN 0 4 2000 32. Hygistrar's Signatura

DHMH 16 Rev 6/95

2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0	1	0	0	0
U		0	U	1

					,	Cert	ificate of	Death	,	Reg. No.	U .	O LUUZ.
	Discolat		1. Decedant's Nama (First, Middla,	Last)					2. Date of Dea	ith Day	Year	3. Tima of Death
П	Physicia /Medic	-	Ernest G. Malle	ette					Januar			2:25 AM
	Examin	_	4e Fecility Neme (If not Institution,	give street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
			Montgomery Gen	eral Hospit	a1			Olney		Montg	gomer	У
	Funeral		5. Social Security Number 6	5. Sex 7. A	ga (In yrs. las		If Under 1 Yaar Months Days			r, Year)	9. Birthp	place (State or Foreign
	Director		215-01-4674	102.11	96	Yrs.			Nov 4,	1903	Mis	sissippi
	and and		Usuel Residence of Decedenf 10a. Stata 10b. County	-	10c. City,	Town or Loc	ation				1	0d. Insida City Limits
	4 she	ō	W11 W		0	1 0	•					1 ☐ Yes 2 No
	the the	Director	Maryland Mont	gomery	sand	dy Spr	10f. Zip Coda			10g. Citizen of	Whet Cour	ntry?
	3a or		17401 Quaker Li	n			208	60		USA		
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Evar in U,S.	13. W		Hispanic Orlgin? (S pen, Maxican, Puar	Specify Yas or No-		e - Amaric	
0	or He	F	1 Navar Married 2 Marrie		No 192	3-	Yas, specify Cut		to Hican, etc.)	100	ck, White,	atc.
22	in 72 hours after death with the Maryland "natural", or Hems 23a or 28a-f show legical Examiner must be notified at	l by	3 XWidowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:	1926		LI TOS ZUNO	эресну:		Specify	y:	hite
21215-0020	72 h	Completed	15. Decedent's (Specify only highest			(Giva k	int's Usual Occu ind of work dona	duning most of wo	rking	16b. Kind of B	usinass/in	dustry
12	d within giene. r than	du	Elamantary/Secondary (0-12)	Collaga (1-4or	5+)		O NOT usa ratire	9d)				
7	tygie ther t		12 17. Father'a Nama (First, Middla, La	eti		Con	tractor	18 Mother's Na	ma (First, Middla,	Constru		n
Baltimore, Maryland	od of od of	o Be	James Mallette	31)					Mallette		ila)	
2	should be and Mental	F	19a. Informant's Name/Raletionship	(Type Print)		10h Mailine	Address (Street	and Number or Ri			State 7in	Code)
Z Z	d2 s than 7 le		Thomas Knowles					ven Dr, S				
e,	Heal Heal		20a. Mathod of Disposition	Filend	20b. Pla	ce of Dispos	ition (Nama of		Data	20c. Location		
U OL	ages ant of t: # #		1 Burlel 2 Cremation 3 4 Donation 5 Other (Spe		3		atory or other pla		Jan 10	Brenty	boot	MD
	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 ie marked other any injury or other traumatic evant, it		21. Signatura of Funaral Sarvice Lie		FOI		coln Cer	ass of Facility Hi				
Ba	Dependent of the police of the		Alan 1	Done	00							g, MD 2090
)	Physician /Medical		23a. Part1. Entar tha diseese, of or shock, or heert feilura. List or immadiata Ceuse (Final	molications that cause in one ceuse on each l								Approximate Interval Between Onset end Deeth
	Examiner		disease or condition rasulting in death)	a		ult Ke as a consequ		ry Distre	ess_Synar	ome	-	5 hrs
		ner			•			Accident				18 hrs
	cuted	am	Sequentially list conditions,	b		is a consequ		11001111				10 1120
Ö,	e exe	EX	Sequantially list conditions, if any, laeding to immadiata causa. Entar Underlying Causa (Disaase or Injury									
68760,	rificate be executed ng physician and s as the bunal-transit	edical Examine	that Initiated avents resulting in daeth) Lest	C	Dua to (or a	s a consequ	anca of):	1				
				.								
ROX	death ce	lan		d								
	v requires that the death cer been signed by the attendir should be deteched for use	Physician/M	Pert II. Other significant conditions	contributing to death !	out not result	ing in tha und	darlying causa g	ivan In Part I.	23b. Dld 1	obacco uae co	ntributa t	the cause of death?
J.	that the	P.							10	Yes 2X No	3 Pro	bably 4 Unknown
or Vital Records,	requires l	d by							24e Was	en autopsy	24b. W	ere autopsy findings
Ö	been	Completed								mad?	av	allabla prior to implation of causa
ě	2 8 8	E C										death?
<u></u>	certificate rector, pag		25. Was casa rafarred to medical							′as 2√ No	11	☐ Yas 2☐ No
5	Physician: The I this certificate ha	o Be	axaminar? 1 ☐ Yas 2 ☐ No	Hospital:	innt 2 🗆 🗆	R/Outpatient	3□ DOA O	thor	ath (Check only o		ner /Casai	6-1
	Phys eral di	n: To	27. Manner of Death	28a. Data of Inji (Month, De	-	8b. Tima of	28c. Inju		28d. Dascribe h			<i>y</i> /
0	Attending P r death. ector: After by the funer	atlo	1 XNatural 5 ☐ Panding 2 ☐ Accident Invastiga		ey Year)	Injury		Yas 2 No				
DIVISION	or Attendest efter desti Director: d in by the	HICE	3 Suicida 6 Could no datamin	A Zoa. Place of in	jury - At hom	e, ferm, stra	at, factory, office				ber or Run	al Routa Number,
5	s effect of Direction	Certification:	4 [] Florifolds	building, e	fc. (Specify)				City or Tow	n, Stata)		
	To the Hospital or Attending Phwithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral	edical		Physician: To the best saminer: On the basis of and mannar si	of axamination							
	Within To the	ž	29b. Signatura and titla of certifiar	-	_		29c. Licen	se number		29d. Data signa	d (Month,	Day, Year)
			D. Wen	m, ~	> _		D35	045		January	y 3,	2000
7		-	30. Nama end eddress of person wh	no completed causa of	daath (Itam 2	3a) (Type, P						
			Philip G. Hen	jum, MD 34	416 01	andwoo	d Ct, #	204, Olne	ey, MD 20	0832		
	Sta	te	31. Deta filed (Month, Dey, Yaar)	32. Regist	rar's Signatu	re	-					

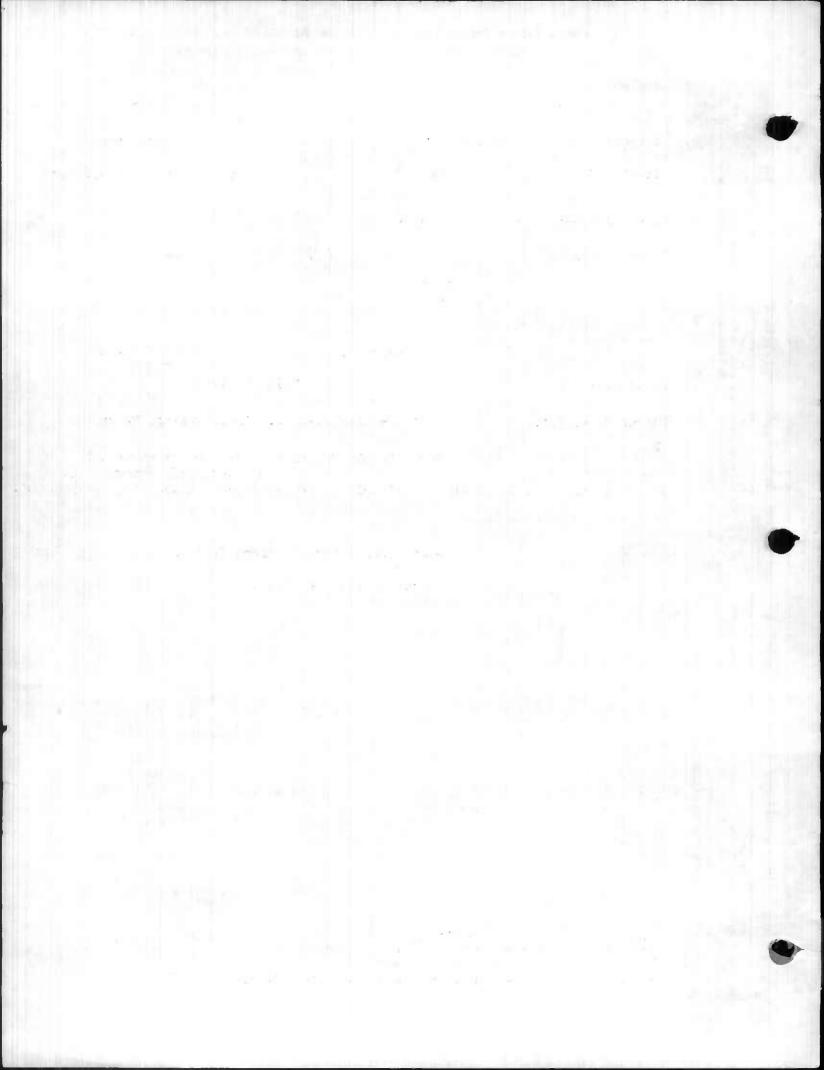
JAN 05 2000

books

DHMH 16 Rev 6/95

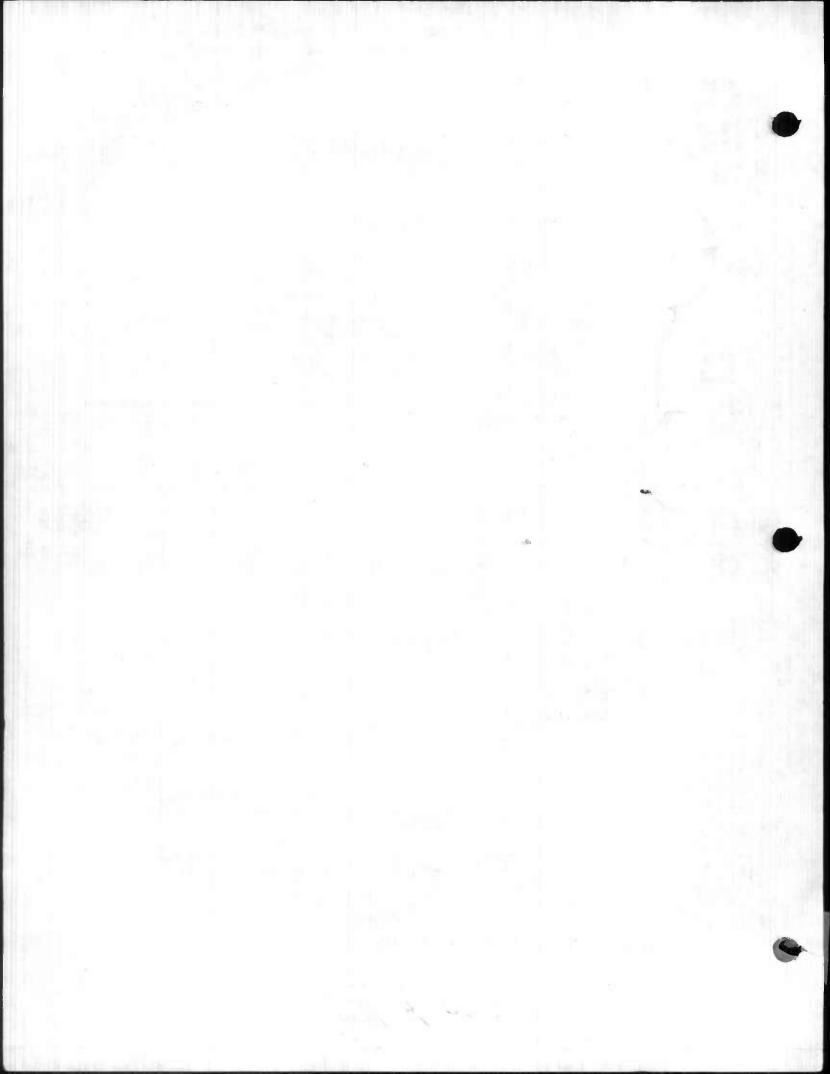
State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 1, 2000 Gabriella Edith Moses January 1:20 AM /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Brooke Grove Rehab. & Nursing Center Montgomery Sandy Spring ff Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Hours 1□M 2♥F 79 Yrs. 041-28-1702 Director April 1, 1920 Hungary Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show I notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Bethesda Directo 10e. Street and Number 10f. Zin Code 10n Citizen of What Country? r than "natural", or items 23e or the Medical Examiner must be a 4405 East-West Highway, Suite 201 20814-4533 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 No b altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed ment of Health and Mental Hyga set; if then 27 is marked other any or other traumatic event, the Not Available Not Available Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 89 Not Available Not Available 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert M. McCarthy/ Attorney 4405 East-West Highway, #210, Bethesda, MD 20814 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Jan. 13, Department of Important: If 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Arlington National Cemetery Arlington. Virginia 21. Signeture of Funeral Service Licensi 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 100689 in the dileese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, the first results only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Brain Cancer 1 year diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner sician and burtal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician is the burial Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of): 60 980 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I, 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Alzheimer Dementia by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 has 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Pending after death. Director: Af investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide 24 hours 29e, Certifier 1XI Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mes Michael Anchor D29730 January 2, 2000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Michael Anchors, M.D. 16220 S. Frederick Rd, Suite 210, Gaithersburg, MD 20877 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State JAN 0 4 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

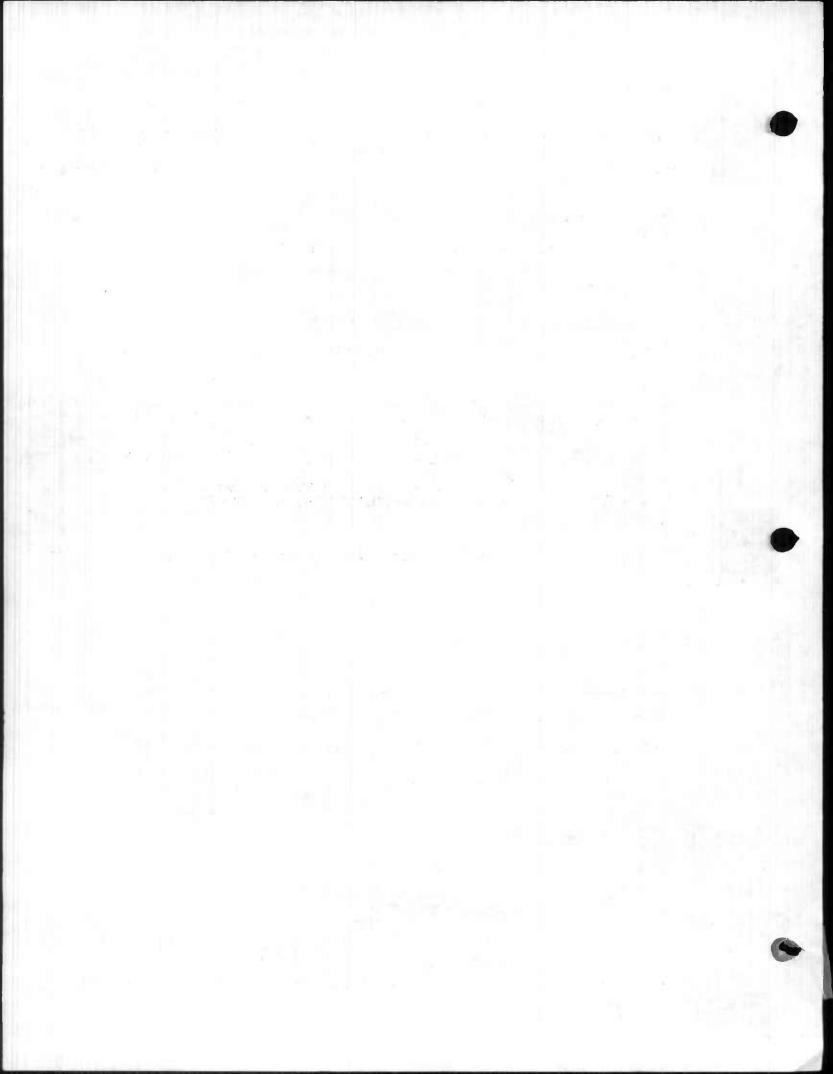
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day 2000 **Physician** 2, JAN. 5:00 AM FRANCES E. MOORE /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Silver Spring MONTGOMERY 9302 Piney Branch Rd., #103 8. Data of Birth (Month, Day, Year)
June 22,1930 If Under 24 Hrs. If Under 1 Year 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months Days Hours 1 ■ M 2 🕮 F Maryland 69 578-36-4805 Director Usual Rasidence of Decedant The Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Montgomery Silver Spring MD Directo 10a. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? WITH 9302 Piney Branch Rd., #103 20903 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene 172 hours after a Important: if them 27 is merited other than "netural; or then any injury or other traumatic event, the Medical Franciscopies. Biack, Whita, atc. 1 Nevar Married 2 Married ☐ Yas 2 No Yas, Giva Specify: Black Baltimore, Maryland 21215-0020 1 Yas 2 Mo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Domestic Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Besse Dodson Paul C. Kelley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip CodeMD 2090B 19a. Informant's Name/Ralationship (Type, Print) 9302 Piney Branch Rd., #103, Silver Spring James Moore (Husband) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 1/6/00 Sandy Spring, MD Mutual Mem. Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licansas 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Causa (Final Chronic Obstructive Pulmonary Disease vears disease or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): for use as 99 signed by the e Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? Yes 2 No 3 Probably 4 Unknown Lung Cancer Stage IIIB Non small cell þ 24b. Wara autopsy tindings available prior to complation of causa of death? should should Completed 24a. Was an autopsy Radiation pneumunitis, Coronary Artery Disease pege 2 : 1 ☐ Yes 2 No Noninsulin dependent diabetes 1 Yas 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case rafarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation 1X Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide edical 29a. Certifier 🖾 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and due to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 00 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 10810 Connecticut Ave., Kensington, MD 20895 Neelam Shaw, M.D. 31. Data filed (Month, Day, Year) JAN 05 2000 32. Registrar's Signatura State

DHMH 16 Ray 6/95

Registrar

Creva

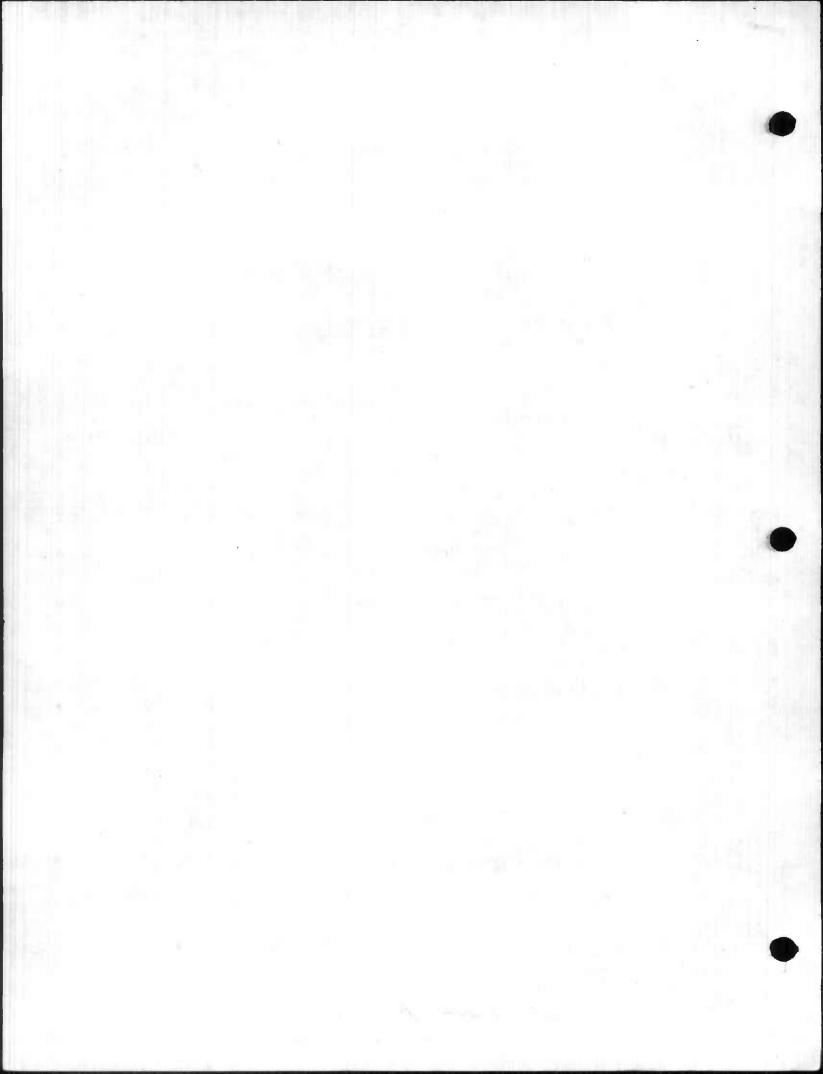


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** ROBERT MILLMAN MD Jan. 1 2000 12:01 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPI'IAL

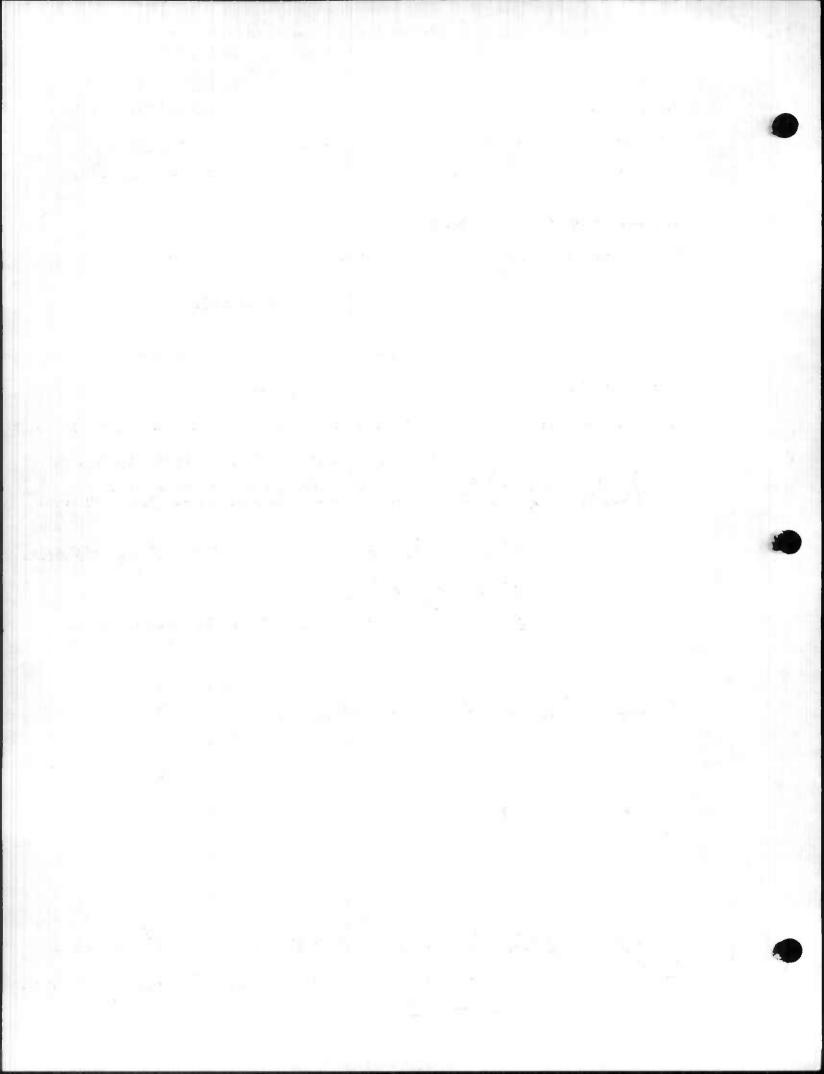
| 7. Age (In yrs. lest birthday) SHADY GROVE
5. Social Security Number ROCKVILLE MONTGOMERY H Under 1 Year 9. Birthplace (Stata or Foreign WASHINGTON, DC **Funeral** 1፟፟M 2□ F 213-42-6160 55 Director Usual Rasidence of Dacedant 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show MD MONTGOMERY GAITHERSBURG XX Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a 100 KENT OAKS WAY 20878 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc. hours after 1 Nevar Married 2 Married natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: À Specify: WHITE 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry fled within 72 Hygiene. College (1-4or 5+) Elamentary/Secondary (0-12) PHYSICIAN MEDICAL permit. Pages 1 and 2 should be file.
Department of Health and Media 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 2 LEONARD MILLMAN LILLIAN SPERLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari Perry, DAUGHTER 12142 SKIP JACK DR, GERMANTOWN, MD 20874 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata cematary, crematory or other place) 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) COMFORT CREMATORY 1-3-00 ALEXANDRIA, VA 21. Signatura of Funaral Sarvice Licens 22, Nama and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. Mock 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part I. Entar the disease, or complications that ceuses the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximata Interval Between Onset and Death **Physician** CARCINGUE OF PANCREMS /Medical Immediata Causa (Final 2 weeks disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed sician and buriel-trans Sequentially list conditions, if any, leading to Immadiate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. physician s the buriel Physician/Medical Due to (or as a consequence of) signed by the e P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 : 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Yas 2 No 1 2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending invastigation 1 ENatural death. 1 Yes 2 No 2 Accidant efter death filled in by the 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours e To the Funeral C completely filled 29a. Cartifiar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. ş 29b. Signatura and titia of certified 29d. Data signed (Month, Day, Year) 0 1,2000 10 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Contr by Rockerthe Md. 20850 MICHAEL D. SULKINMD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State **JAN 0 4** 2000 doark Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	, 0
St.		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physic /Med		Juana Mendez	January 2, 2000 7:14 pm
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death 4c. County of Death
A		Washington Adventist Hospital Takoma	a Park Montgomery
Funeral	г	5 Coolel County Number 6 Cov 7 And the use to satisfact a 16 Lindor 1 Voor 16 Lindor	r 24 Hrs. 8 Date of Birth 9 Birthplace /State or Foreign
Director		216-19-7023 Usual Residence of Dacadant	Min. (Month, Day, Year) Mar 28, 1928 El Salvador
ryland how		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
with the Maryland e or 28a-f show Le notfied at	Funeral Director	Maryland Montgomery Takoma Park	1 ☐ Yes 2Ã No
Mary Mary	ä	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
€ 23	a	8706 Barron Street, Apt 7 20912	El Salvador
after or the	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexical New Yes are or Dates:	
naturel;	ted	15. Dacedent's Education 16a. Dacedent's Usual Occupation	
i i i i i	Completed	15. Dacedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+)	st of working
e filed wit al Hygiene other the	S	1 Homemaker	Own Home
ta de	Be	17. Father's Name (First, Middle, Last) 18. Moth	ar's Nama (First, Middla, Maiden Sumama)
d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	LO L	Gregorio Mendez Paul	a Argueta
and and is me			per or Rural Route Numbar, City or Town, Stata, Zip Coda)
amil. Pages 1 and 2 should be filed with mortanes of Health and Mental Hygiens reported to the filed with hygiens 27 is marked other than it him you other traumatic event, the min.		Will Rurial 2 Cremation 3 Removed from State	NW, Apt 121, Washington, DC 200 20c. Location - City or Town, State
all the second		21. Significant Funeral Service Licensee 22. Name and Address of Facility	y 1/6/2000 Silver Spring, MD
Dept may amy annot		Francis J. Coll	ins Funeral Home, Inc. Blvd,W, Silver Spring, MD 20901
ifficate be executed with a physician and as the bundal-transit as the bundal-transit as the second	ledical Examiner	Sequentially list conditions, b. Esophagea/ Varia	tind Bleeding 48 house ces nd Portal Hypertension.
v requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/M	d. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part	23b. Did tobacco use contribute to the cause of death
that that	by Phys	Insulin Dependent Diabetes Mellitu	/
ne law requires a has been sign ige 2 should be	Completed b		24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death?
F # 8	000		1 ☐ Yes 2 ☐ No
rtific ctor,	Be	25. Was case referred to medical 26. Plac	a of Death (Check only one)
> 0 0	To	axaminar/	ursing Home 5 ☐ Residence 6 ☐ Other (Specify)
ing Phi ing Phi ing Phi ing Phi ing Phi ing Phi		27. Mannar of Death 1 S Natural 5 □ Panding 28a. Data of trijury (Month, Day Year) 28b. Tima of Injury at Work?	28d. Dascribe how injury occurred
To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident Invastigation 3 ☐ Suicide 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (Straet and Number or Rural Route Number, City or Town, Stata)
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai C	29a. Certifiar (Check only one) Madical Examiner: On the best of my knowledge, death occurred at the tima, data and mannar stated. Madical Examiner: On the basis of examination and/or investigation, in my opinion, data and mannar stated.	nd place, and dua to tha cause(s) and manner as stated. ath occurred at the time, data and place, and dua to the causa(s)
vithir Fo th	Me	29b. Signature and title of commo	29d. Date signed (Month, Day, Year)
9		to to Boull MD D35	
ı		30 Name and address of person who complated cause of daath (Item 23a) (Type, Print)	055 01/03/2000 ille Rd. Silver Spring 14d 209.
		JOSE F. BONELY, MD 8807 Cokesu	ille Rd. Silver Spring Md Inc
Sta	_	31. Data filed (Month, Day, Year) 1AN 0 4 20000 32. Registrar's Signatura	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01007 Certificate of Death 2. Dete of Death 3. Time of Death Month Day Year Dorothy Meade JAN 2000 0950 4b. City. Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE M If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) MONTGOMERY 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days

1. Decedent's Neme (First, Middle, Last) **Physician** /Medical 4a Facility Name (If not institution, give street and number) Examiner 5. Social Security Number **Funeral** 93 579-60-4674 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location ahow the Marylan r 28a-f show .notified at Director Maryland Montgomery Rockville 10e Street and Number ò Barra 23a 1515 Dunster Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status o flied within 72 hours after di If Hygiene. other than "natural", or item 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important. If Item 27 is marked other that any injury or other traumetic event, that 2008. 12 17. Father's Neme (First, Middle, Last) 88 William Benjamin Meade 19e. Informent's Neme/Reletionship (Type, Print) Robert S. Sanford/Nephew-in-law 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Ligans Lover M00672 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediate Cause (Final aspiration disease or condition resulting in death) Examiner

10f. Zio Code 10g, Citizen of What Country? 20854 United States 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: White 1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Government Secretary 18. Mother's Neme (First, Middle, Meiden Sumeme) Leila Q. Wood 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Brice Road, Rockville, Maryland 20852 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Jan. 4, 20c. Location - City or Town, State

2000 Bethesda, Maryland Montgomery Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Intervel Between Onset and Deeth

Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

preumonia Due to (or as a consequence of)

Due to (or es a consequence of):

Due to (or as a consequence of):

Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. asthma

disease

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

3, 1906 Washington,

10d. toside City Limits

1 No Yes 2 No

24e. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

4 days

2 No

1 Yes 2 No

25. Wes case referred to medicat examiner? 1 Yes 2 No

hyportersian

coronary artery

5 Pending

Hospitel: tnpatient 2□ ER/Outpatient 3□ DOA 28b. Time of

28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)

27. Manner of Death

1.ENaturat

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steled.

29c. License number

29b. Signeture and little of certifier elood. Ar Mb

51889

29d. Date signed (Month, Dey, Year) JAN -1-00

10

iclan and burial-transit

physician

signed by the a

this

After

death.

e Hospital or Attendi n 24 hours after death e Funeral Director: A pletely filled in by tha f

To the Hosp within 24 hor To the Fune completely fi

þ

Completed

8

Certification: To

Medical

the

The law requires that the death certificate be executed

Box 68760.

Records. P.O.

Division of Vital Attending Physician:

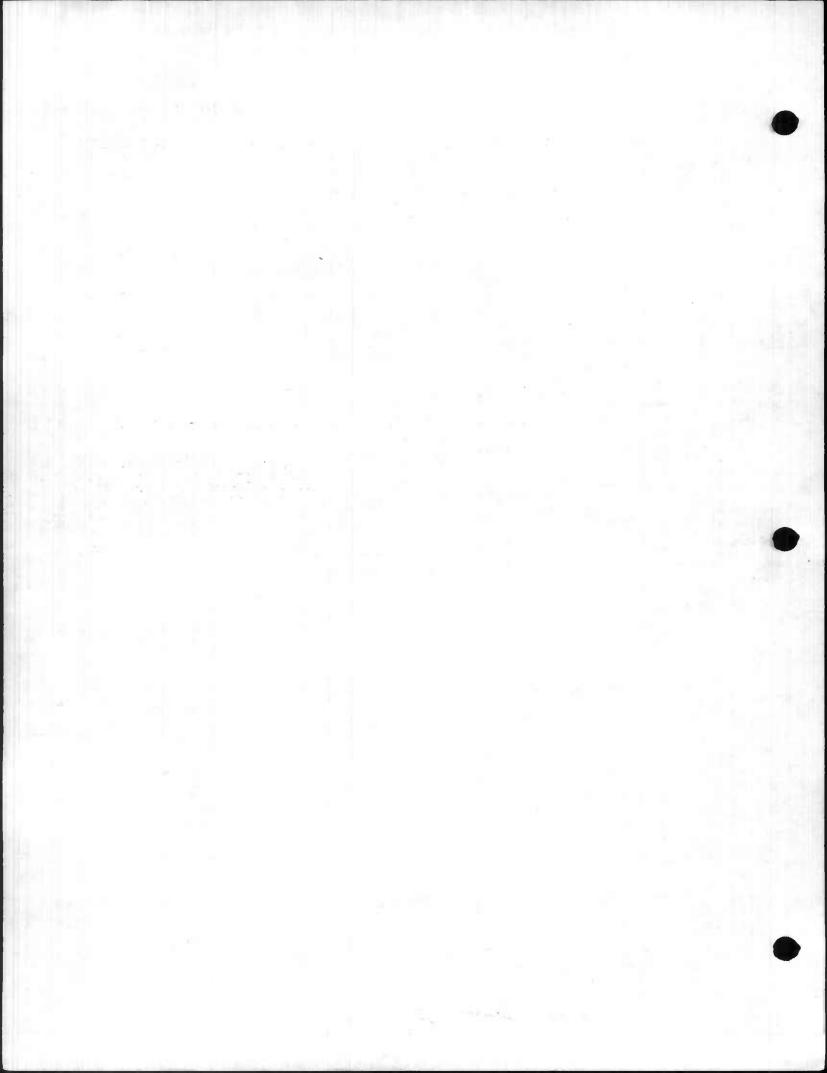
30. Name and address of person who completed cause of death (ttern 23a) (Type, Print)

Deborah Rost 15225 MD

Gove Ra ROCKVIII MD 20850

State Registrar

31. Date filed (Month, Day, Year) JAN 0 4 2000 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month VARI **Physician** Edward Donald Mateik January 4, 2000 22:40 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9227 East Parkhill Drive Bethesda Montgomery If Under 1 Veer Birthplaca (State or Foreign Country) If Undar 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Davs 1 M 2 □ F 80 277-12-8894 Dec. 10, Director Ohio Usual Rasidenca of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9227 East Parkhill Drive 20814 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yas 2 No 1939 — If Yes, Give 14. Race - American Indian, traumatic event, the Madical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of anti-city and Mental Hygiene. The Health end Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White >q 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1981 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) United States Eiementary/Secondary (0-12) College (1-4or 5+) Officer Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steven John Mateik Josephine Zamek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye E. Naylor/Daughter 10121 Watkins Road, Gaithersburg, Maryland 20882 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Jan. 21, 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 10 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 2000 21 Signature of Funeral Service Line 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01126 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical disease Immediate Cause (Final pronary disease or condition resulting in death) Examiner Due to (of as a consequence of) Examiner certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last physician and the bunal-tran Due to (or as a consequence of): Physician/Medical Dua to (or as a consequenca of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 94 detached signed by t 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed Deed hes 2 2 No 2 X No 1 Yes 1 Yes certificate Attending Physician: 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer 1 Natural 5 Pending Injury or Attending after death. 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier (Check only one) 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifie

Vanuary

State

Registrar

ricid

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Hem 23a)

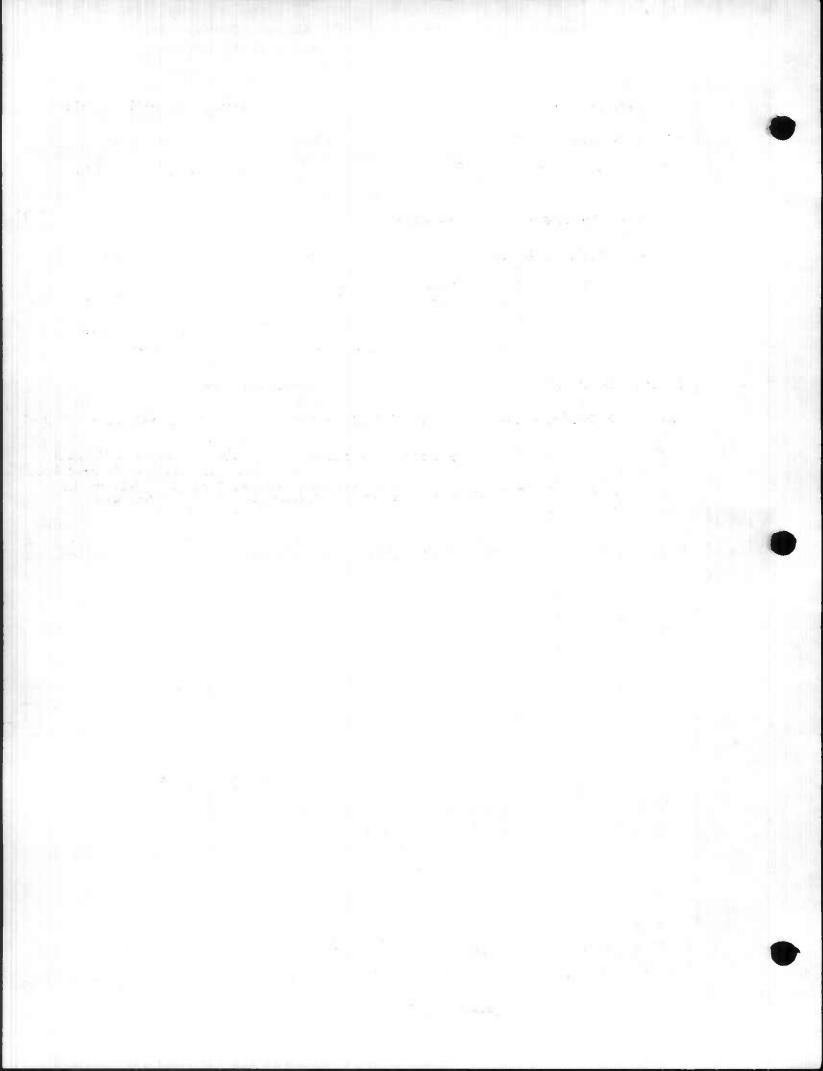
32 5

egistrar's Signature

lomsko.

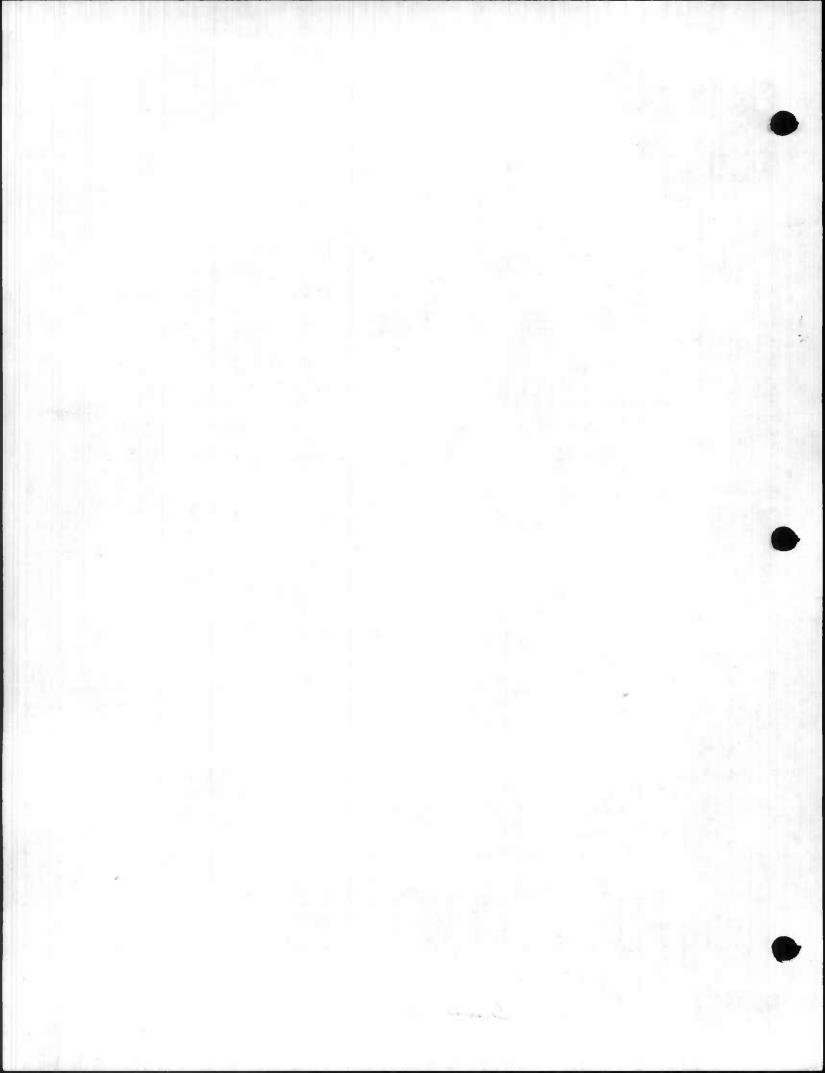
JAN 0 7 2000

15+1



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	0	Reg. No.	01009
Dhualaian	1. Decedent's Neme (First, Middle, L	est)				2. Date of De	ath Dev	3. Time of Death
Physician /Medical	Joseph Martin Ma	ntusek ve street end number)			4b. City, Town, or	January Location of Death	4, 2000	9:00 PM
Examiner	13301 Collingwo				Silver S		Montg	
Funeral	5. Social Security Number 6.	Sex 7. Age (In	yrs. lest birthde	ay) If Under 1 Year Months Days	If Under 24 Hrs	8. Dete of Birl	h Veerl	9. Birtholace /State or Forei
Director	577-44-5751 Usual Residence of Decedent	10XM 2DF 65) Yrs.	MONITS Days	Mills Mills	8. Dete of Birt (Month, De Oct 21,	1934	Pennsylvania
Mow M	10a. Stete 10b. County	10c	. City, Town or	Location				10d. Inside City Limit
e Ma tified ctor	Maryland Montgom	ery Si	ilver S	pring				1 ☐ Yes 2Ã N
iar death with the Maryla literas 23e or 28e-f sho ner must be notified at 'uneral Director	10a. Street and Number			10f. Zip Code			10g. Citizen of W	That Country?
Aust i	13301 Collingwood	7		20904			USA	
ther death in the them 23 siner must have proved the function of the them and the them and the	11. Merital Status	12. Was Decedent Ever Armed Forces?	n U,S. 1	Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Bleck	- American Indian, k, White, etc.
Mr. or Exami	1 ☐ Never Merried 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	1 🖾 Yes 2 🗌 No If Yes, Give Yeer or Detes:	1955 - 1957	1 Yes 2 No	Specify:		Specify.	White
ed within 72 ho ygione. wer then "naturn f, the Medical. Completed	15. Decedent's E (Specify only highest gi	ducation ede completed)	/G	cedent's Usuel Occupive kind of work done	during most of wo	orking	16b. Kind of Bu	siness/Industry 1 Bank of
withing the Man	Elementery/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retire	d)		Washing	
D THE	17. Father's Name (First, Middle, Las		Comp	troller	18. Mother's Ne	ame (First, Middle,		
Mental Hy riked othe atic event.	Joseph Albert Ma					lores Mar		
s marked and Mentu a marked aumatic e	19e. Informent's Neme/Reletionship		19b. M	eiling Address (Street				State, Zip Code)
27 ha	EleanorN. Matuse	k/ Wife	133	Ol Collins	wood Ter	race. Si	lver Sp	ring, MD 2090
of He	20a. Method of Disposition	20	h Place of Dis	sposition (Neme of cremetory or other ple	1	Dete	20c. Location -	City or Town, State
Pag internal	1 Burlel 2 ☐ Cremetion 3 (4 ☐ Donation 5 ☐ Other (Spec	JRemovel from State fy)		ncoln Ceme		1/10/200	00 Brent	wood, MD
partment popularities of portant: If y injury or issue.	21. Signature of Puneral Service Lice	DS66		22. Name end Addre	ess of Facility			
88 1 28	1/Kobert Es	Carnsey		Francis J.				lnc. pring, MD 209
	23e. Part1. Enter the diseese, or conshock, or heart feilure. List only	plicetions thet cause the	leeth. Do not	enter the mode of dyi	ng, such as cardie	ic or respiratory a	rest,	Approximete Intervel Between
Physician	31001, 31110011101101. 210(311)	one edge on each inte.						Onset and Deeth
/Medical	Immediate Cause (Final disease or condition	11	ING	CANCE	R			2 years
Examiner	resulting in deeth)		to (or as e con					
n and latransit Examiner		b						
physician and street transit sthe burtal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or es e cons	sequence of):				t t
	Cause (Disease or injury that initiated events	C						
ng physicie as the bur Medical	resulting in death) Last	Due t	o (or es a c <i>on</i> s	sequence or):				
attending for use a	_	d						
d by the attendidetached for use	Part II. Other algnificant conditions	contributing to death but not	resulting in the	e underlying cause gi	ven in Pert I.	23b. Did	tobacco use con	tribute to the cause of dea
ed by the detached							Yaa 2□ No	3) Probably 4 ☐ Unknown
be det								
been signed b should be deta leted by Pl							en eutopsy med?	24b. Were autopsy finding aveilable prior to
2 2 2								completion of cause of death?
page Com						101	res 2 No	1 ☐ Yes 2 ☐ No
s certificate director, pa	25. Was case referred to medical axeminer?					eath (Check only o	one)	
를 구	1 Yes 25 No		2 ER/Outpet	Herit 3LI DOA		Home 5 Resid		
	27. Manner of Death 1 Netural 5 Pending	28a. Dete of Injury (Month, Dey Yea	r) 28b. Time Injur	y Wo		28d. Describe	now injury occurr	ed
death tor: the	2 Accident investigation 3 Suicide 6 Could not t		M. h. a. m		Yes 2□No	20f Leasting (Dennet and Month	as as Burni Bouto Mumber
affector: Affect ed in by the funer Certification:	4 Homicide determined	28e. Plece of Injury - / building, etc. (Sp	ecify)	street, rectory, bride		City or Tox	vn, Stete)	er or Rural Route Number.
within 24 house after death. To the Funeral Director: A completely filled in by the ft. Medical Certificati	29e. Certifier 1 Certifying P	nysician: To the best of my miner: On the basis of exam	knowledge, de	eth occurred at the ti	me, date and plac	e, end due to the	cause(s) and me	nner as stated.
in 24	one)	and manner steted.	mietion artoro			uneo et the time,	date and piece, a	inc due to the cause(s)
Z Son Z	29b. Signature and title of certifier	1.		29c. Licens	and the second second		29d. Date signed	(Month, Day, Year)
10+1	Joseph >	and son		0 2	21910		January	6,2000
	30. Name and address of person who	completed cause of death (1tem 23a) (Typ	De, Print) Fe CY	ara 1	Or M	Theaten	MD 2091
	101						OTICALI	,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Physician VIRGINIA MASENHEIMER 1800 LAURA 2000 01 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner SILVER SPRING 9106 LINTON STREET MONTEOMERY If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 24,1918 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1□M 21 F 190-12-0746 Yrs Maryland 81 **Director** Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle nent of Health and Mental Hygiene.

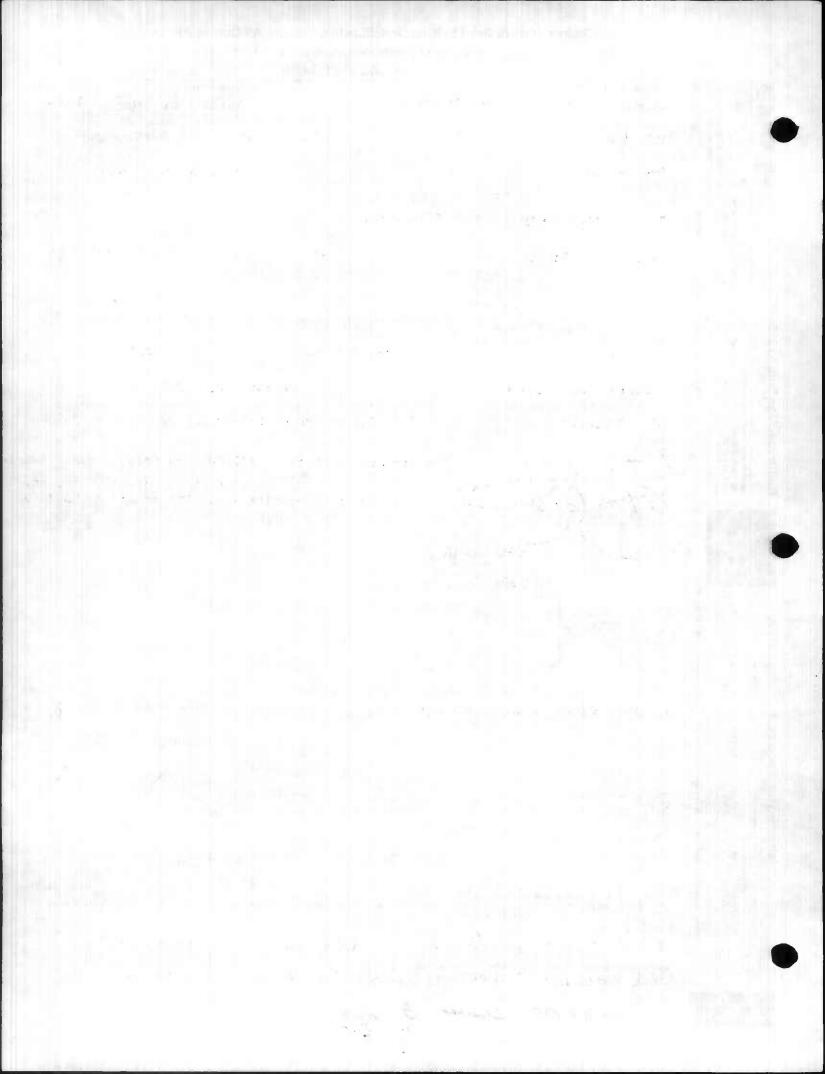
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other treumstic event, the Medical Examples of the Incitted at 1 Yes 20No Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of 20901 9106 Linton Street Funeral America 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grada complated) Elementary/Secondery (0-12) Coilege (1-4or 5+) Loan Officer Banking 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be McCullough Martha E. Eduard A. Imwold 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Silver Spring, Maryland 20906 3732 Bel Pre Road Olga Coats/Sister 20b. Pleca of Disposition (Neme of cematery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 Burlai 2 □ Cremetion 3 □ Removel from State 1/7/00 New Freedom, Pennsylvania New Freedom Cemetery 22. Name end Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Serv Silver Spring, MD 20904 11800 New Hampshire Ave. Nions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, oguse on each line. Pert1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Figure dise to our condition /Medical Avonovia Examiner resulting in death) Due to (or as e consequenca of): CANCINOMA & BLEAST Examiner ettending physician and for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of) Box 68760. Physician/Medical Due to (or es e consequenca of) 88 P.O. signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANTER ISCURRATIC CALDIOURSCULAR OWENER Division of Vital Records, þ 24b. Were eutopsy findings evaileble prior to 24e. Was en autopsy Completed completion of cause of deeth? pege 2 s 1 ☐ Yes 2 NO 1 Yes certificate or Attending Physicien: funeral director 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending after death. 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29a, Certifie 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner as stated. Medical To the Hosp within 24 hos To the Fune completely fi Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signa nd little of cartifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year) mo. (ono) 015236 soos, 10 travat

State Registrar 31. Dete filed (Month, Day, Year) JAN 03 2000

30. Name end eddress of person who completed cause of death (flem 23a) (Type, Print)

AND WARBOLD MD (OME) 11/25 (POCKVILLE FIRE, POCKVILLE, MO 2089 32. Registrer's Signeture

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Day **Physician** Month Year Michael John Nisos 2000 JAN 4 2:52 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 □ F 228-12-0730 77 Yrs Director May 30, 1922 Virginia Usuai Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at the Marvie 1 ☐ Yas 2 No Maryland Montgomery Bethesda Directo 10e. Street and Number 10f. Zip Coda 10c Citizan of What Country? 9219 East Parkhill Drive 20814 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or its 1 ☐ Nevar Married 2 X Married 1 XYas 2 No If Yas, Giva Yaar or Datas: 1944–1967 1 ☐ Yas 2 No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collega (1-4or 5+) Consultant Private Industry 5+ 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) John Nisos Esteliani Dermizakis 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Amalina G. Nisos/Wife 9219 East Parkhill Drive, Bethesda, Maryland 20814 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovai from State January 19 any injury or Arlington National Cemetery 2000 4 □ Donation 5 □ Other (Specify) Arlington, Virginia Robert A. Pumphrey Funeral Home/Bethesda-Chevy-Chase, M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Entar tha disaasa, or com shock, or haart fallura. List only all caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, by each line. Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) HEMOTHORAX Examiner Dua to (or as a consequence of) physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that inhitiated evants resulting in death) Last Due to (or as a consequence of): Physician/Medicai tha Dua to (or as a consequence of) usa as attanding jo ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Š should 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has cartificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartific 25. Was casa rafarred to medicel axaminar?
1 ☐ Yas 2 ☑ No Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Mannar of Death Certification: 28h. Tima of 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not ba 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled filled 17 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 06

12+

Saltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

State Registrar

JAMES LAWLER, 31. Data filed (Month, Day, Year) JAN 0 7 2000

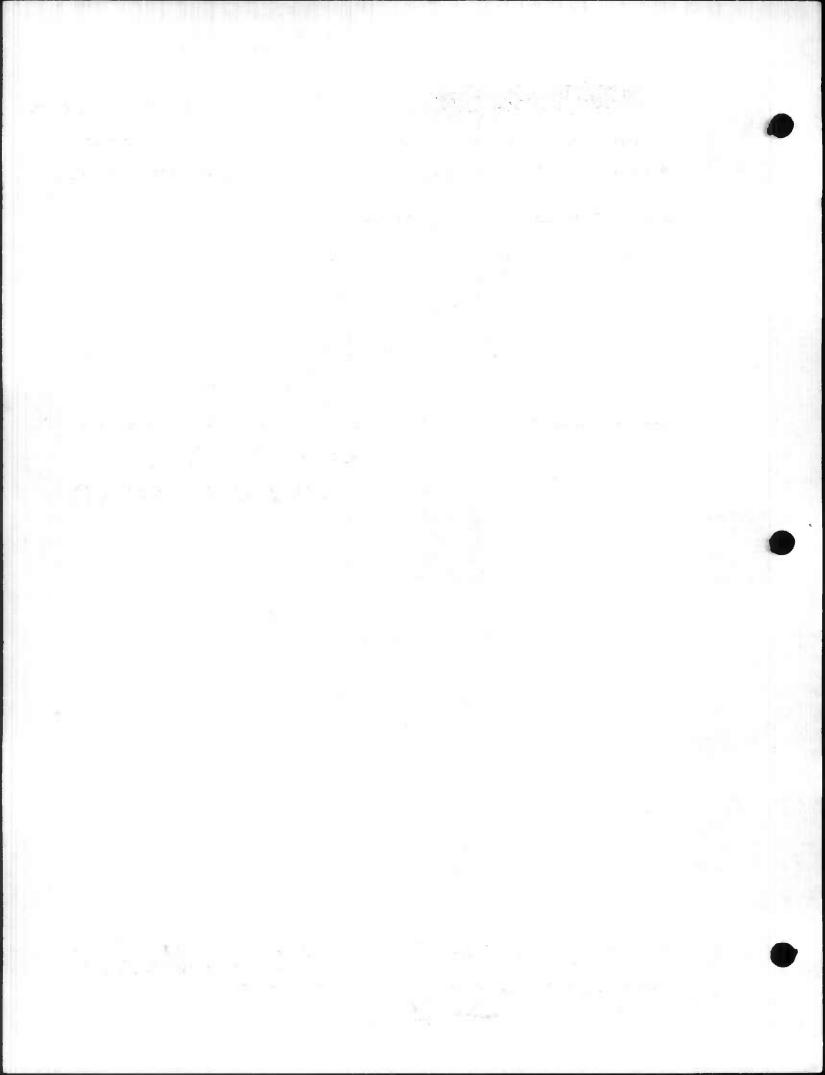
30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)

LT, MC, USN 32. Registrar's Signatura BETHESDA MD 20889-5600

97-01454 (NC)

NATIONAL MAVAL MEDICAL CENTER

00



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

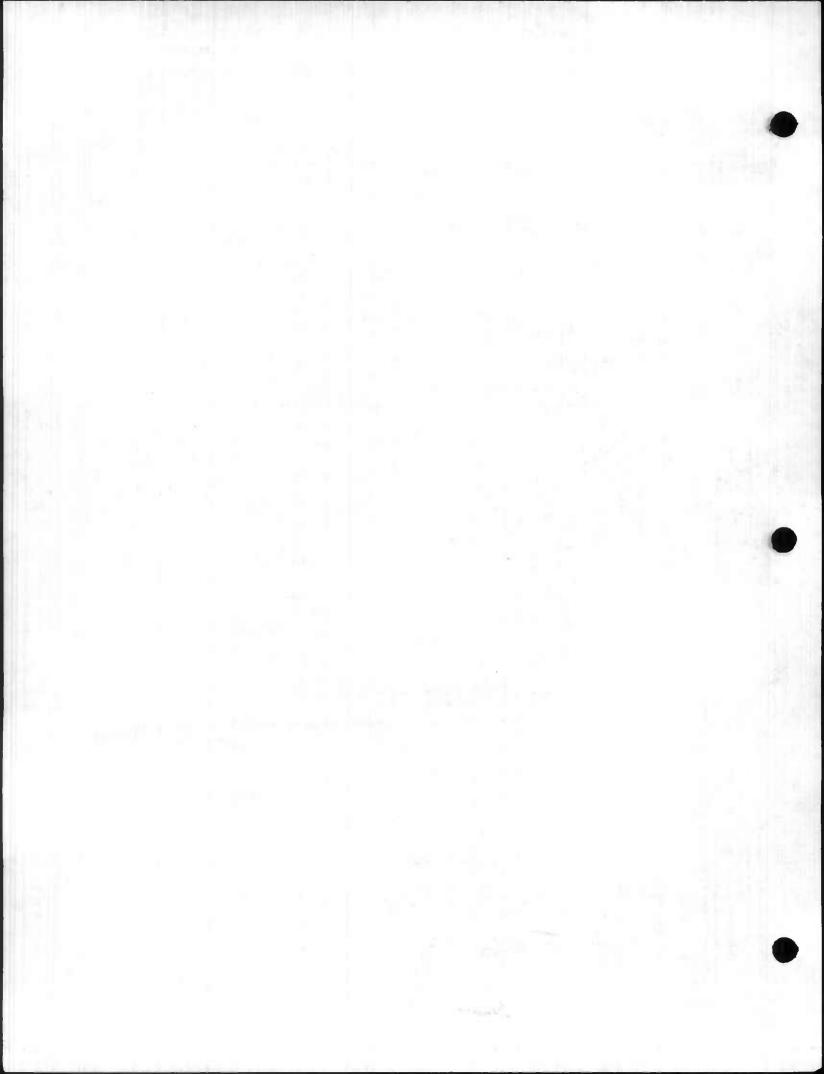
			Otate of Ivial	•	Certificate of			eg. No.	UI	012
П	Dhusisian	1. Decedent'a Nama (First, Middla, La	st)				2. Data of Deal Month	Day	Year	3. Time of Death
	Physician /Medical	Charles A. Ogleba	ıy, Jr.				Januar		00	10:54 am
	Examiner	4a Facility Nama (If not institution, giv	a street and number)			4b. City, Town, or		4c. County	of Death	
		Holy Cross Hospit				Silver S		Montgo		
	Funeral Director	216-18-1037	DAY OF E	(In yrs. lest birth 75 Y	day) If Undar 1 Yaar Months Days	If Under 24 Hrs. Hours Min.		1924	9. Birthplace Country) Maryla	e (Stata or Foraign nd
	puet #	Usual Rasidance of Decedant 10a. Stefa 10b. County	1	IOc. City, Town	or Location				10d.	Inside City Limits
	Mary Tor	Maryland Montgome	erv	Silver	Spring					1 ☐ Yes 2 ☐ No
	or 28=4 s	10e. Street and Number	-		10f. Zip Coda		1	0g. Citizan of V	Vhet Country	7
	h with	810 Forest Glen F	Road		20901		U	SA		
	r items 23 other ment	11. Marital Status	12. Wes Decedant Ev Armed Forces?		13. Was Decedant of H	lispanic Origin? (S	pecify Yes or No-		e - Amarican I	
Baltimore, Maryland 21215-0020	by	1 ☐ Navar Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Z Yes 2 No If Yas, Giva Year or Datas:	1943- 1945	1 ☐ Yas 2 ☐ No	Specify:	o i noun, ato.,	7	: White	
5-0	ed within 72 ho ygiene. for then "nature ft, fre tendical Completed	15. Decedant's Ec	ducetion	16a. (Decedant's Usual Occup Giva kind of work dona	pation	rkina	16b. Kind of Bu	isinass/Indust	iry
121		Elemantary/Secondary (0-12)	College (1-4or 5+)		lifa. DO NOT usa ratire	d)				
12	offled within of Hygiene. other than vent, re the	17. Fathar's Nama (First, Middla, Last)	4	Cer	tified Publ	1	ntant ma (First, Middla, I	Federal		nment
and	0 - > 0							Meineri Sumeni	9)	
Z	12 should be 1 n and Mentel I is marked of raumatic eve To Be	Charles A. Oglebay		10h	Mailing Addrass (Street	Rena Mae		City or Tourn	State Zin Co	ode)
Ma	d 2 s th en th en trau									
e,	Heal Heal	La Verda L. Ogle		20b. Place of I	O Forest G.Disposition (Nema of cramatory or other pla	ten koau,		20c. Location -		
U	D THE D	1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)			ke's Cemete		1/8/2000	Cumber	land .	MD
E	permit. Pages 1 and 2 should be Department of Health and Mante Important: If tem 27 is marked eny injury or other traumatic ance.	21. Signatura of Funaral Sarvice Licer	·		22, Nema and Addre					
ä	Departimon Important	1	7.0		Francis J.					
	Physician /Medical Examiner	23a. Part f. Infer the disaasa, or com shock, or haart failura. List only Immediate Causa (Final disaase or condition resulting In death)	ona couse on aechlina.	al Infa		ng, such as cerdia	c or raspiratory arr	ast,	Int Or	proximata tarval Batween nset end Death
	غ سست		Coronary						1	
	executed in end ial-transit	Sequentially list conditions.	V		onsaquance of):					
0	e exe	Sequantially list conditions, if any, leeding to immadiata ceusa. Entar Undarlying Causa (Diseasa or injury							8	
68760,	tificate be executed g physician and es the burial-transit	that initiated events rasulting in death) Lest	CDu	a to (or as a co	nsequance of):					
Box	at the death certified by the ettending letached for use ethysician/M		d							
	deat be eff ed fo	Part II. Other eignificant conditions o	ontributing to deeth but	not resulting In	the underlying cause give	van in Part I.	23b. Did to	bacco use co	ntribute to the	e cause of death?
P.0	that the death certined by the ettending a detached for use ey Physician/M						1□ Y	ee 2□ No	3 Probab	ly 4 Unknown
ecords,	been sign should be should be						24a. Wes a perfor		availa	autopsy findings bla prior fo letion of ceuse ath?
Œ	certificate hes rector, page 2						1 🗆 Y	as 2000	1 🗆 Y	as 2000
ita	iclan: certifica ector,	25. Wes cese referred to medicel axaminar?				28. Place of De	eth (Check only or	10)		
5	2 00	1 Yas 25 No	Hospital: 1 ☐ Inpatiant	2 DER/Out	patient 3 DOA Oth	her: 4 Nursing I	loma 5 □ Reside	ence 6 DOth	er (Specify)	
n	ng Pl	27. Manner of Déath DNatural 5 □ Panding	28e. Data of Injury (Month, Dey Y	(ear) 28b. Ti	ury Wo		28d. Describe h	ow Injury occur	red	
Division of Vital Record	To the Hospital or Attending Physic within 24 hours efter death. To the Funeral Director: After this of completely filled in by the funeral director. Medical Certification: To	2 Accident Invastigation 3 Suicida 6 Could not be 4 Homicide determined		/ - At home, fare (Specify)	m, streat, factory, office	Yas 2□No	28f. Location (S City or Town		er or Rural R	outa Number,
f	Hospitu 4 houn Funera tely fille	29a. Cartifiar 175 Certifying Ph (Check only one) 2 Medical Exam	yefclan: To the best of r ntnar: On the basis of an and mannar state	xamination and	death occurred at the ti	ma, date and place opinion, death occu	a, and due to the curred et the time, d	ause(s) and ma ate and place,	nnar es state and due to the	ed. e cause(s)
	within 2 To the comple	29b. Signature end fitte of certifiar	and marifiel state	-	29c. Licans	sa number	2	9d. Data signe	d (Month, De	y, Year)
	. 1	Danka a	Loon		1	2201		1/0	100	
	10 * 1	30. Nama and addrass of person who	completed cause of dear	th (Item 23a) (T	vpe, Print)	R.D. Ande	erson	. / 8	,	
		1500 Fase	04 COL	u Ro	Silw	Sprin	V UL	705	de	
	State	31. Data filed (Month, Dey, Year)	32. Registrer's	s Signetura	land		1			



Piease Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 0 1 3

					C	ertificate of	Death		Re	g. No.	6		
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Death	1		3. Time of	Death
	Physic		Claud	e_Worthington	Outon	Īν			Month January	Dey	Year	4:35	nm.
	/Medi Examir		4a Facility Neme (If not institution, give		Owell		4b. City, To		ation of Death	4c. County		4.33	Pill
7	EXAITII	iei			od		1	Oct om					
			5. Social Security Number 6. S	simmon Tree Ro ex 7. Age (In yrs.		(v) If Under 1 Yeer	If Under	Otom	8. Date of Birth	<u> </u>		omery	r Foreign
	Funeral Director			X м 2□ F 79	Yrs.	Months Days	Hours	Min.	(Month, Day, February 2	Year) 20,1920	Wash	lace (State of try) ington	, D.C
	the Maryland Starf show sottlind at	J.O.	10a. Steta 10b. County		y, Town or						1	0d. Inside Ci	
	2 70	Directo	Maryland Montgor	nery			Potoma	ıc					
	f 8 8		10e. Street and Number 9200 Persit	mmon Tree Road		10f. Zip Code	20854	4	10	g. Citizen of V Unite			
	death ms 23	Funeral	11. Merital Status	12. Was Decedent Ever in U. Armed Forces?		. Was Decedent of H			cify Yes or No-	14. Rac	e - Americ	an Indien,	
0	72 hours after hatural", or its dical Examine		1 ☐ Never Merried 2 Narried	1 X Yes 2 □ No		1 Yes 2 No		, ruento r	rican, etc.)		k, White,	atc.	
02	E. F.	þ	3 Widowed 4 Divorced	If Yes, Give Year or Detes: WW	ET.	TIL Tes 201 NO	Specify:			Specify		ite	
21215-0020	72 ho	Completed	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Dec	edent's Usual Occup	pation	of working	1	6b. Kind of Bu			
2	2 . 5 %	ple	Elementery/Secondery (0-12)	College (1-4or 5+)	life	re kind of work done DO NOT use retired	d) mosi	OF WORKIN	9				
2	D de de	NO.		3		Enginee	r			Me	chan	ical	
P	11.68	86 0	17. Father's Name (First, Middle, Last)				18. Mothe	r's Neme	(First, Middle, M	laiden Suman	10)		
ā	Abertia See of	TOE	Claude	W. Owen, Sr.					Emma Scl	hafer			
Maryland	2 shot and N is man	-	19a. Informant's Neme/Relationship (7		19b. Ma	iling Address (Street	and Numbe				Stata, Zip	Code)	
	and 2 saith a n 27 is er trai		Patricia Cox Owen	/ Wife	9200	Persimmo	n Tro	Pos	d Potom	ac Mai	cv1 an	4 2085	5/1
re,	- f 5 fi		20a. Method of Disposition	20b. P	Place of Dis	position (Name of		itoa		Oc. Location -			, -
Baltimore,	Pages hant of in mry or o		1 ☐ Burial 2 X Cremation 3 ☐	Hemovei from State		ematory or other pla	,		nuary				
븚			4 Donation 5 Other (Specify	PIOTI	tgome	ry Cremato	rium]	nc.5	,2000 I	Betheso	la, M	arylan	.d
Ba	Depart Import any in		21. Signature of Fundal Service Licen	Collet MOO3	R	22. Name and Address obert A. ethesda-C	Pumphi hevy	cey F	uneral	Home/ 7557 W:	iscon	sin Av	/enue
			23a. Part1. Enter the disease, or come shock, or heart failure. List only	milions that caused the deet	h. Do not e	nter the mode of dyir	ng, such es	cardiac or	respiratory arre	st,		Approximate Interval Beh	е
	Physician /Medical Examiner	ner	Immediate Ceuse (Final disease or condition resulting in death)	a. <u>Atheroscle</u> Due to (o		Cardiova equence of):	scula	r Dis	ease		1 1	Onset and I	20011
	end end I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (c	r as e cons	equence of):							
x 68760,	artificate be executed ing physician end e as the bunel-transit	Medical	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	C. Due to (or	r as a consi	equence of):					i		
Box	s that the death certifica ned by the attending ph e detached for use as ti	by Physician	Part II. Other significant conditions co	ontributing to death but not res	uiting in the	underlying cause giv	ren in Part I		23b. Did tot	Decco use co	ntribute to	the cause o	of death?
P.0.	that the ed by th detach	/ Phys	Normal Pressure							a 2□ No	3 Pro		Unknown
Records,	aw requires is been sig 2 should b	Completed by							24a. Wes an perform		av:	ere autopsy f silable prior to mpletion of co death?	0
		50							1 ☐ Yes	s 2 No	10	Yes 2	No
Vital	ilclan: Th certificate rector, pag	Be	25. Was case referred to medical				26. Place	of Death	(Check only one)	-		-
>	yalclan: is certific director,	ToE	axaminer? 1 X Yas 2 No	Hospital:	ER/Outpati	ent 3 DOA Oth	100		ne 5 🕅 Resider		er (Snecif	v)	100
o uo	Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injur		2	8d. Describe how		-	,	
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ome, ferm, s				8f. Location (Str. City or Town,	eet and Numb State)	er or Rura	I Route Num	ber,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b	edicai (29e. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	relctan: To the best of my know iner: On the basis of examinat and manner steted.	wledge, dea tion and/or i	th occurred at the tir nvestigation, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the car d at the time, da	use(s) and ma te and place,	nner as si and due to	ated. the cause(s)
	Fo the Fo the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29	d. Dete signe	d (Month,	Day, Year)	
	10+	1	1 500	20/	3	>	D3993	/1		Januar	37 5	2000	
	10		30. Name and eddress of person who c	omnieted cause of death /lten	23el /Time		ט פיפינע	4		Januar	у Э,	2000	
4							#202	D = -1		Ma1	nd 00	050	
	Sto	_	Steven T. Coulter, 31. Dete filed (Month, Day, Year)	M.D. 15ZUI Sr 32. Registrar's Signe				KOCK	ville,	пагута	11u _ 2U	0002	
	Sta Registr		JAN 0 7 200		Ø.	sporks	1						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Julia Perez January 03, 2000 12:45 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (Il not Institution, give street and number) 4c. County of Death **Examiner** 7901 Carroll Avenue Takoma Park Montgomery If Under 24 Hrs. H Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10 M 20 F Yrs. 92 Director 580-20-9265 JAN.6, Puerto Rico Usuel Residence of Decedent the Menyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or frame 23a or 28a-f ahov the Matical Examiner must be notified at 1 Ves 2 No Directo Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 7901 Carroll Avenue United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Bleck, Whita, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1½ Yes 2□ No Specify: Puerto Rican Baitimore, Maryland 21215-0020 Specify: P 3 ☐ Widowed 4 ☐ Divorced white "natural" Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 i Hygiene. Seventh-Day Elementary/Secondery (0-12) College (1-4or 5+) Bible Instructor Adventist Church 8 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Tiburcio Perez Concepcion Collado 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Ruth M. Rivera Daughter 7901 Carroll Ave., Takoma Park, Maryland 20912 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other piece) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Gate of Heaven Cemetery 1/7/2000 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Rapp Funeral & Cremation Services,
Stephen D. Lohrmann, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910 21. Signeture of Funeral Service Lice Re M00956 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Causa (Finel 3 Years disease or condition resulting in death) a Colon Cancer Metastatic to Lung Examiner Due to (or as a consequence of) Examiner be axecuted physician and the burief-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 an/Medicai Due to (or es a consequence of): 080 Po Physici ed by the e Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t d be detach 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Hypertension, Atherosclerotic Division of Vital Records. p 24a. Was an autopsy performed? 24b. Were sutopsy findings available prior to Completed peeu Cardiovascular Disease completion of cause of death? has page 2 The 1 Yes 2 No 1 ☐ Yes 2 No certificate Physician: Be 25. Was case referred to medical axeminer?
1 ☐ Yes 2∑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Certification: Affer Attending 1 Neturel 5 Pending e Hospital or Attendin 24 hours after death. e Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely f Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check a) onel 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and January 04, 2000 D35055 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) F. Bonelli, M.D., 8807 Colesville Rd., 5th Fl., Silver Spring, Maryland 20910

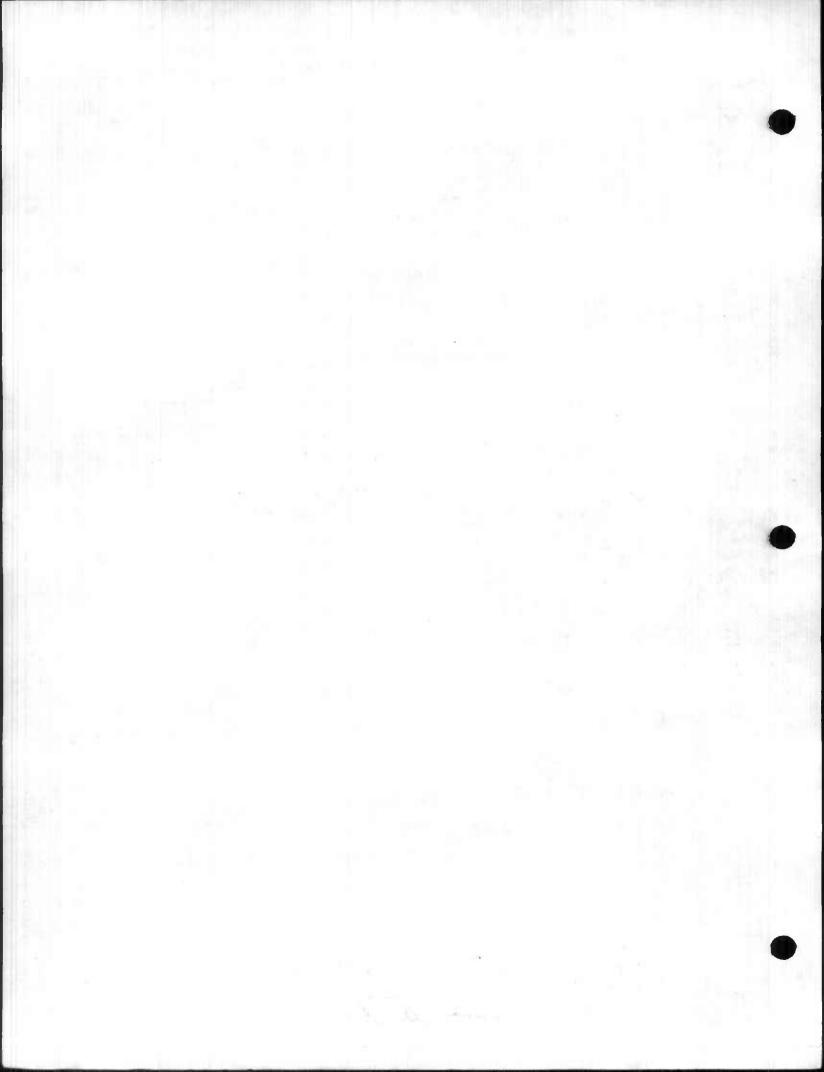
Registrar

State

31. Dete filed (Month, Dey, Year)

JAN 07 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Parks Willis Monroe 2000 12:15 am January 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Deers Head Center 6. Sex 12 M 2□ F If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) March 18 1934 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 214-30-9177 65 Yrs Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 6 Richardson Drive U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 Yes XNo Specify: white ii Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) electrician construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Russell Parks Mertye Todd Hudson 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6 Richardson Drive, Cambridge MD 21613 19e. Informant's Name/Reletionship (Type, Print) Patsy E. Parks - wife 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date XX Burial 2 Cremetion 3 Removal from State Dorchester Memorial Park 1-5-2000 Cambridge, Md. 4 Donation 5 Other (Specify) uneral Service Liced 22. Name end Address of Facility Thomas Funeral Home, PA 700 Locust St. Cambridge MD 21613 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finei disease or condition resulting in death) immediate myocardial infarction /arrest

Physician /Medical Examiner

Examiner

attending physician and for use es the bunel-trensit

the signed by t

peen

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

þ

Completed

Be

Certification: To

Medical

that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

The law has page 2

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

2

MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f traumetic event, the Medical Examiner must be notifie

filed within 72 hours after Hygiene. Ither than "natural", or its

permit. Pages 1 and 2 abouid be file Department of Health and Mertal Hy Important: If Nem 27 is marked oths any injury or other traumstic event.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest 25. Was case referred to medical examiner?

Due to (or as a consequence of): end stage renal disease Due to (or es a consequence of):

7 weeks Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus S/P epidural abcess / paraplegia

23b. Did tobacco usa contributs to the cause of death? 1 Yes 27 No 3 Probably 4 ☐ Unknown

24e. Was an autopsy 24b. Were autopsy findings performed? 1 Yes 2 No

Jan. 2, 2000

avellebie prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one) 1 Yes ZNO Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpetient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 No

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

D 33905

29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

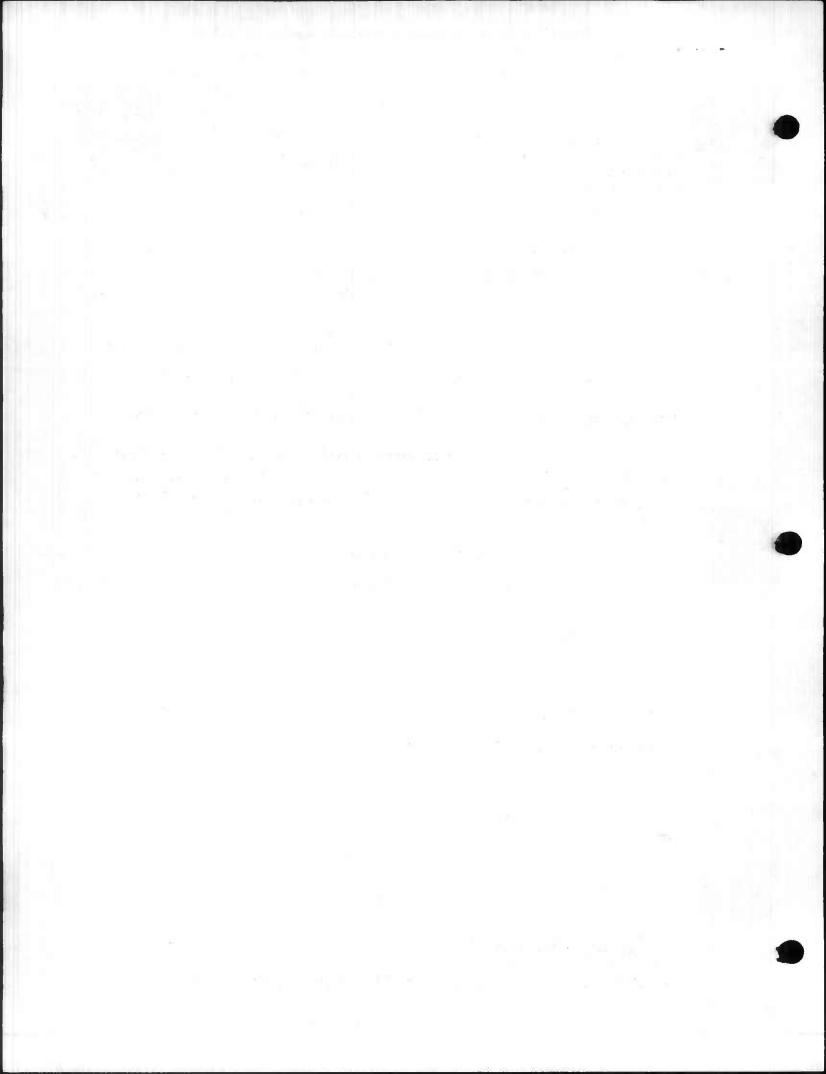
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Virginia A. Dulany, M.D. P.O. Box 2018, Salisbury MD 21802-2018

State Registrar 31. Date filed (Month, Dey, Year) JAN 0 5 2000



いつ



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) Month Dev **Physician** Helen I. Pudney January 4,2000 11:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cherry Lane Nursing Center Prince Georges Laurel If Under 24 Hrs If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F Director 88 212-76-3694 May 19, 1911 Washington, DC Usuel Residence of Deceden 10b. County 10c. City, Town or Location or 28a-f show be notified at 10d. Insida City Limits 1 ☐ Yes 2 No Directo Prince Georges Maryland Hyattsville 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23e or the Medical Examiner must be. Funeral 5810 Riggs Road 20783 USA 14. Rece - Amarican Indien, 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bieck, White, etc. Hisd within 72 hours after Hygiens. other than "natural", or its 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 □ Divorced Yaar or Detas: White Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy,
Importants if fleen Z7 is marked offer 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Lillian F. Frazier Ralph E. Young 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9930 Mallard Drive Roberta J. Gray (daughter) Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta Jan. 7 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel Irom Stata 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Glenwood Cemetery Washington, D.C. 21. Signature of Funerel Service License 22. Nama and Address of Fecility Francis J. Collins Funeral Home, Inc. Robers anse 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each loc. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel CONGESTIVE HEART FAILURE MONTHS disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or ea e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No by 24b. Were autopsy lindings available prior to 24e. Wes an autopsy performed? Completed completion of causa of death? Be Medical Certification: To

certificate be executed and Box 68760 P.O. P 2 been signed t should be det Records, Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

altimore, Maryland 21215-0020

	1 Yes 20 No 1 N							
25. Was casa referre	ed to medical				26. Place of De	eth (Check only one)		
axaminer? 1 ☐ Yes 2 ☑ ⊀	lo	Hospital: 1 Inpatient 2	ER/Outpatient	3□ 1	OOA Other: 4 12 Nursing	Home 5 ☐ Residence	e 6 Other	(Specify)
27. Menner of Death 1 ☑Netural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. injury at Work? 1 Yes 2 No	28d. Describe how i	Injury occurre	d
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		nome, ferm, stree	t, fect	ory, office	281. Location (Stree City or Town, S		or Rurel Route Number,
29a. Certifier	Certifying Ph	ysician: To the best of my kn	owledge, death o	ccurre	d at the tima, date end plac	e, and due to the caus	e(s) end man	ner as stated.

		4	certifier	eture end title of c	29b. Signe
7)	m	/:	//	1.	
1	m	1	11	1	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

024997 Mun a an 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

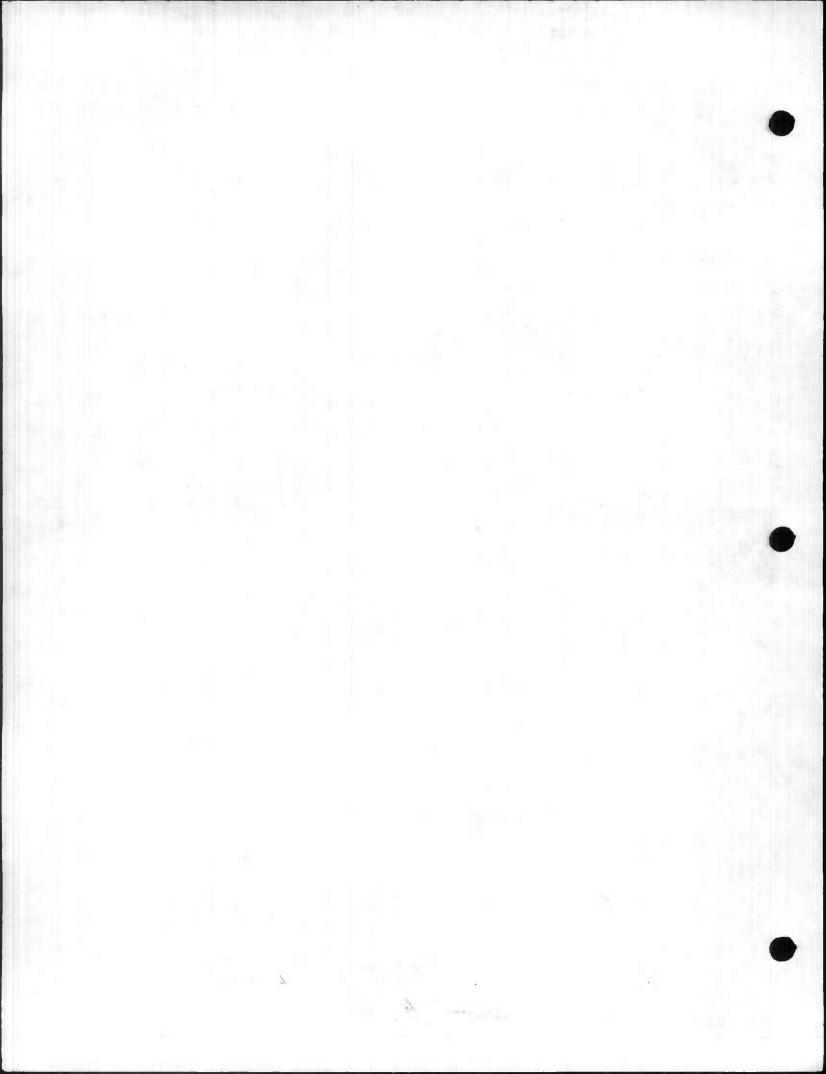
USVE MAKREL MID 20707

1/6/2000

State Registrar

LUIS A. CASAS 31. Date filed (Month, Day, Year) JAN 07 2000

8317 MD CHERRY 32. Registrar's Signature rocks

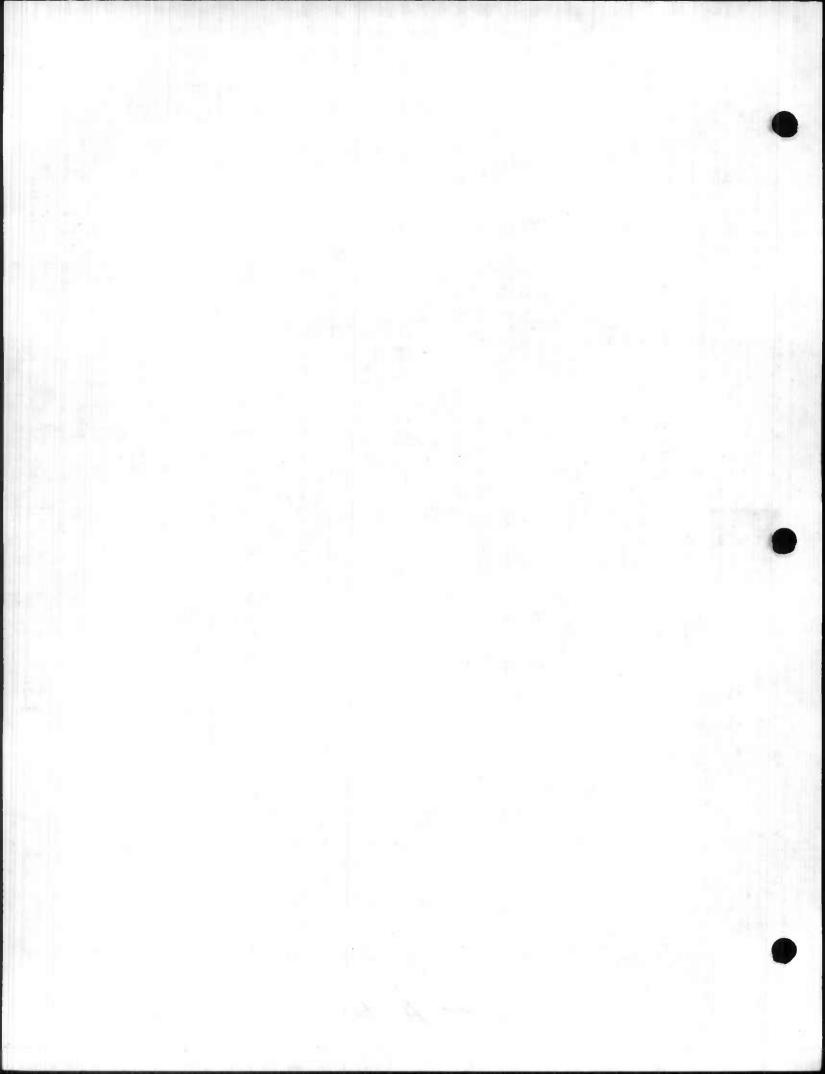


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Roberto Ramos 4, January 8:35 a.m. 2000 /Medical 4a Fscility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Desth Examiner Pine View Future Care Prince George's Clinton If Under 1 Yaar 5. Social Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours Months 110 M 2□ F 87 Yrs Director April 1, 1912 Philippine Islands 576-10-0019 Usual Residence of Decedent the Maryland r 28a-f ahow notified at 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Director Maryland Prince George's Clinton 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 must be 9106 Pine View Lane 20735 United States Nerna 23a death 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, atc. filed within 72 hours after Hygiene. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Never Married 2 ☐ Married altimore. Marviand 21215-0020 1 Yas 2 No Specify: Specify: Filipino Aq 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Hotel Worker Hotels 17. Father's Nema (First, Middla, Last) 18 Mother's Nama (First Middle Maiden Surnema) permit. Pages 1 and 2 ahould be file Department of Heelth and Mentel Hy Important: If them 27 is marked oth any Injury or other traumatic event once. B Unavailable Unavailable 2 19s. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Fisk (Guardian) 1730 K Street, NW, #304, Washington DC 20006 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 1/6/2000 Beltsville, Maryland 21. Signsture of Funeral Service Licensee

22. Nama and Addrass of Facility
Rapp Funeral & Cremation Services,
Rapp Funeral & Cremation Services,
Stephen D. Lohrmann, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate Approximate Intarvsl Batween Onset and Death **Physician** /Medical tmmediate Cause (Finel ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit The law requires that the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 487 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to completion of cause of death? been si 24a. Was an sutopsy performed? Completed certificata has b 1 ☐ Yas 2 No 1 ☐ Yes 2 No Attending Physician: director Be 25. Wss casa refarred to medical 26. Place of Desth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury st Work? After 1 Natural 5 Pending sfter death. Director: Aft 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be detarmined no Hoepital or Attent of the Funeral Director plately filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier Medical 🖒 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date end plece, end dua to tha cause(s) and mannar as atsted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and tifla of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) January 5, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Kaufman, M.D., Louis V. 12070 Old Line Centre, #207, Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State rocks JAN 07 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 8:30 PM ARTHUR A. 1 REIN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HCR MANOR CARE CHEVY CHASE CHEVY CHASE MONTGOMERY 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours Min Yrs. HUNGÁRY 90 577-07-1735 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MONTGOMERY SILVER SPRING MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 USA 11000 INWOOD AVENUE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Bteck, White, etc. 1 ☐ Never Married 2 ☐ Married 1☐ Yes 2☒ No Specify þ 3 N Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTO REPAIR CO-OWNER 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be ADOLPH REIN MOLLIE SCHIFFER 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY J. REIN - SON 8159 NICE WAY SARASOTA, FLORIDA 34238 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/5/00 1 XVBurial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL CONGREGATION B'NAI OXON HILL, MARYLAND 21. Signeture of Funeral Service License 22. Name and Address of Fecili DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the disease. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio muopathi Due to (or es a consequence or): 6 montes disease Examiner war Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No

physicien and s the buriel-transit The lew requires that the death certificets be axecuted Box 68760, 080 Division of Vital Records, P.O. signed by t d be detach certificate has To the Hospital or Atlanding Physician: within 24 hours eftar death.

To the Funeral Director: Atlar this certifica completely filled in by the funeral director, I

Funeral

Director

r than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be lifed within 72 hours effar or Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or ther any injury or other traumatic event. The Medical

Physician

/Medical

Examiner

Baltlmore, Maryland 21215-0020

the Maryland

Medical

3 Suicide

29a. Certifier

4 ☐ Homicide

111 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month. Day, Year) Inhout MD

D51015

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530 WISCONSIN AVENUE #1045, CHEVY CHASE, MARYLAND 20815 ELLEN PINHOLT. M.D. 31. Date filed (Month, Day, Year)

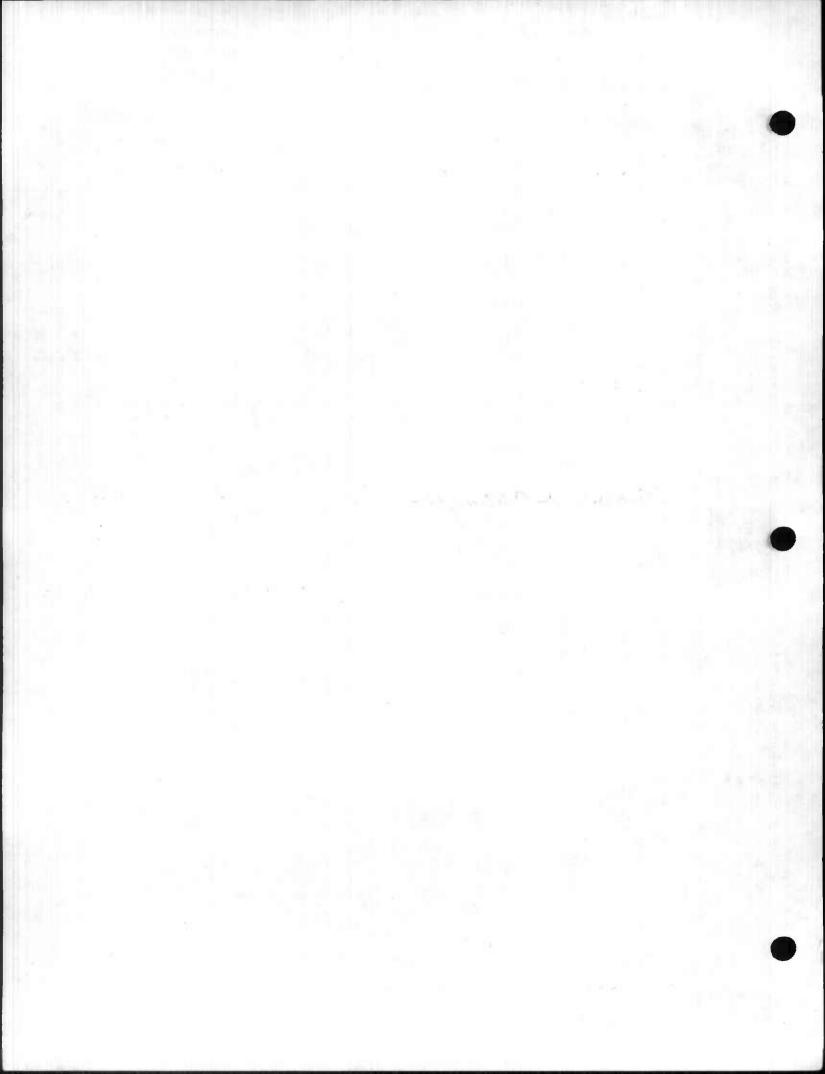
State Registrar

JAN 06

6 Could not be

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

oaks



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 4, 2000 Year **Physician** ROBEY 10:20 AM WILLIAM HENRY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE NURSING & REHAB. CENTER ROCKVILLE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth FEB. 13, 1914 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 □ F VIRGINIA 579 01 1154 85 Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahona MD. MONTGOMERY POTOMAC 1 ☐ Yes 2 No Director 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? "natural", or hams 23a or 10420 BOSWELL LANE 20854 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ğ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 0 CARPENTER CONSTRUCTION 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mantal Hy important: if them 27 is marked oth any Injury or other treumstic svent social. Be V. FRENZEL ROBERT LEE ROBEY ELLEN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6503 CARRIE LYNN COURT, MT.AIRY, MD. 21771 WILLIAM B. ROBEY. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MT. CARMEL CEMETERY 1/8/00 SUNSHINE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MURIEL Address BARBER FUNERAL HOME Bar murie luce P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** STROKE /Medical Immediate Cause (Final WK disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner physician and the buriel-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PNEUMONIA 1 Yes 2 No 3 Probably Wunknown be det by CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed irector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes > No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 80 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide TS Certifying/Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only 29b. Signature and title of gertif 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YASSI MD 31. Date filed (Month, Day, Year)

Su

JAN 0 6 2000

8609 SECOND 32. Registrar's Signature

AVE. #404 B SILVER SPRING MD20910

D 28656

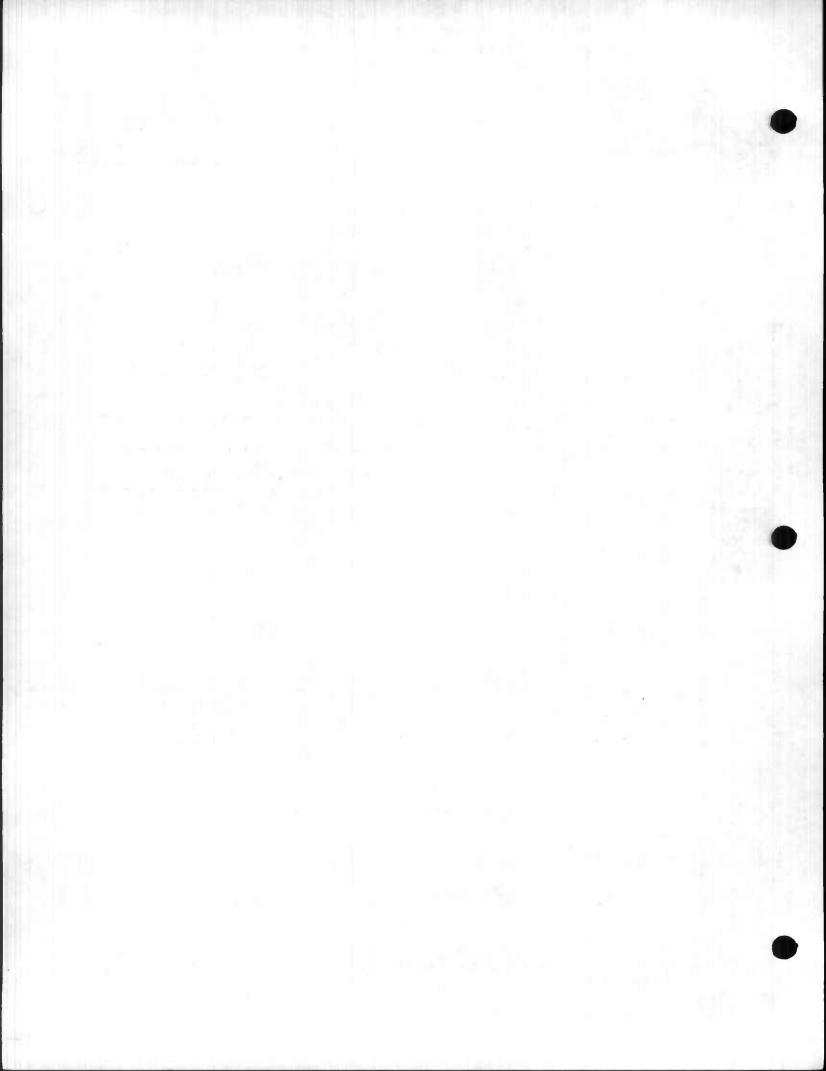
JANUARY 05 2000

altimore, Maryland 21215-0020

P.O. Box 68760

Records.

Division of Vital



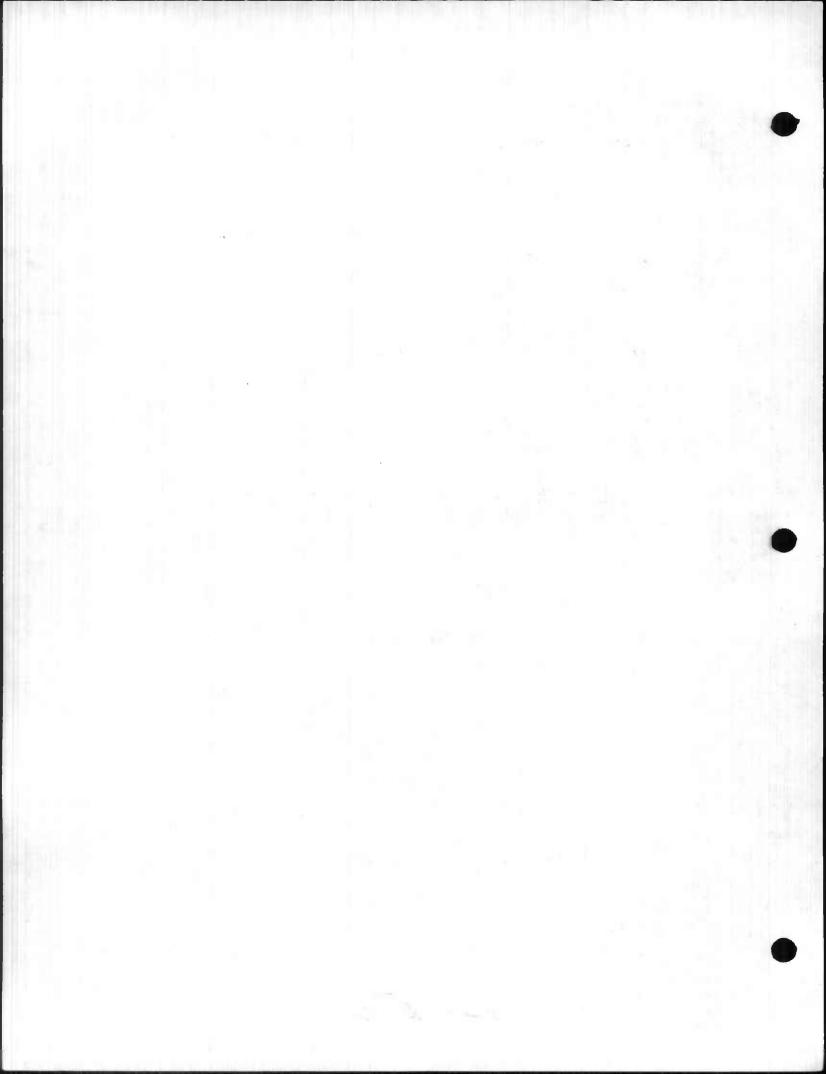
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dev Month **Physician** Betty Lee Payne Romero 2, 2000 5:00PM /Medical January 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Nursing Home Silver Spring Montgomery | SILVOI | FUnder 14 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign Country) **Funeral** 1 M 2 X F Yrs. 578-22-7875 73 Director 9. 1926 North Carolina Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yas 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 8 Norma 23a 20906 Funeral 3700 International Drive United States 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ऒ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, atc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) o filed within 72 hours after of if Hygiene, other than "natural", or item 1 ☐ Never Married 2 N Merried Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-for 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if Nem 27 is marked other tha any Injury or other trearmetic. 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First Middle, Meiden Sumeme) Be Lee Alexander Payne Elizabeth Buchanan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Robert Romero/Husband 3527 Tarkington Lane, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Gate of Heaven Cemetery Jan 2000 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Dones M00672 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on aech line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive Heart Failure Years Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of) 88 USB P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 3 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☼ Unknown Records, à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai Be 25. Was casa referred to medical 28. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edicai Certification: I or Attending Fatter death. After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire letely filled in b To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. (Check only 29b. Signatura and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) B30692 January 3, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Gabriel A. Berrebi, M.D., 15225 Shady Grove Road, #305, Rockville, MD 20850 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 0 4 2000



DHMH 16 Rev 6/95

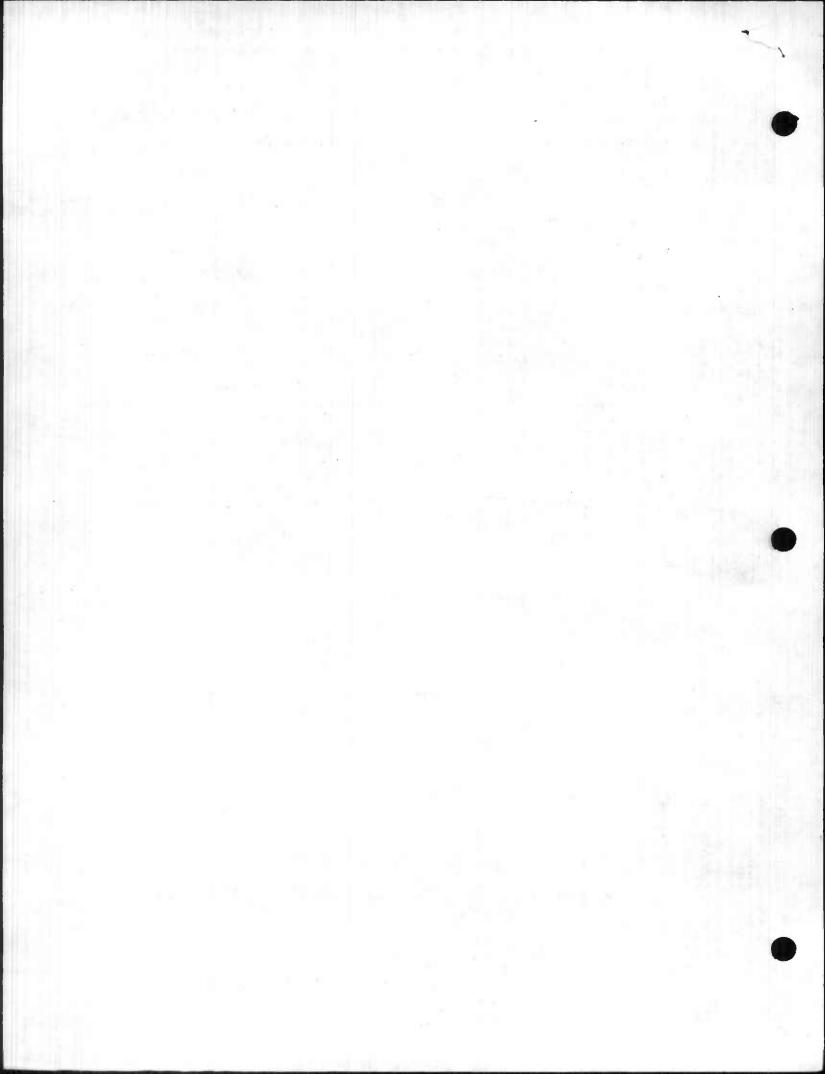
State

Registrar

31. Dete filed (Month, Dey, Year)

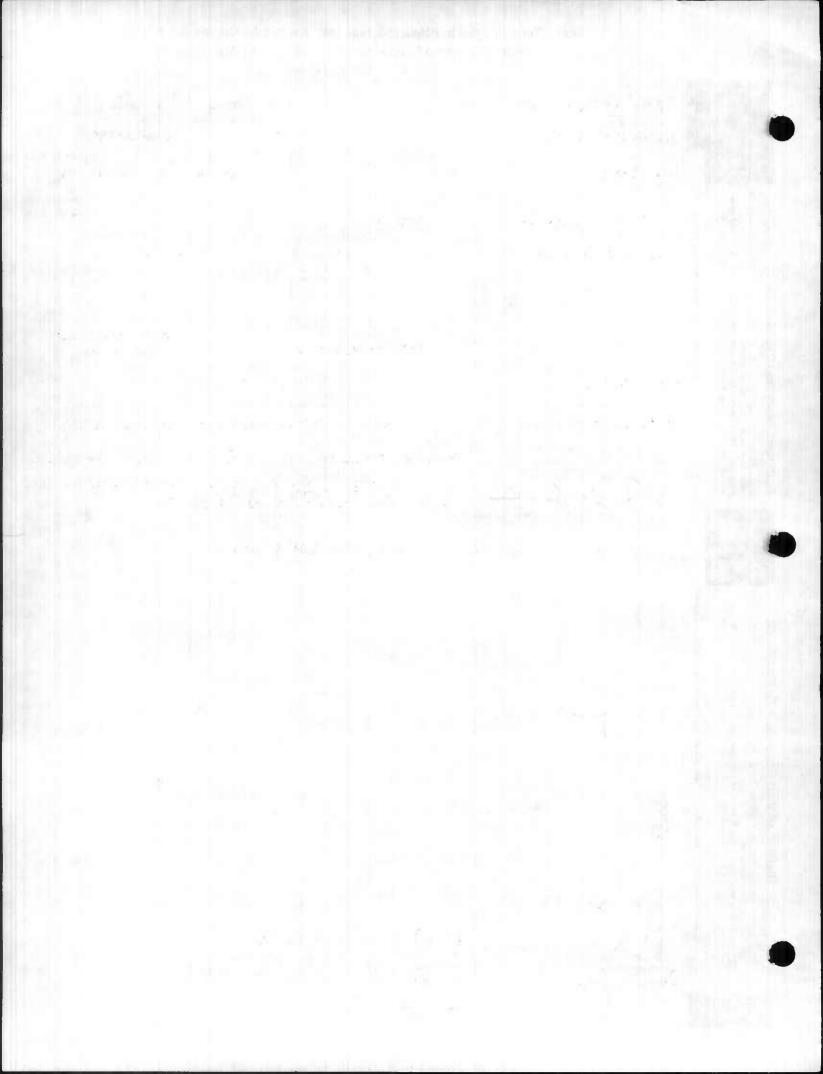
JAN 05 2000

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	Certific	ate of Death	R	leg. No.			
Physician	Decedent's Name (First, Middle, La	SMITH SMITH			2. Date of Dea Month	th Day	Year 21	e of Death	
/Medical Examiner	4a Facility Name (If not institution, give 815 WOODUST DOO'S			4b. City, Town, or ROCK VILLE	Location of Death	4c. County o		- 37	
Funeral Director	5. Social Security Number 6. S 383-34-5988 1	ex	Mont	nder 1 Year If Under 24 Hr. hs Days Hours Min			9. Birthplace (Sta Country) Michigan		
we m	10a. State 10b. County	10c.	City, Town or Location				10d. Insid	le City Limits	
the Maryler 28a-f show notfled at	Maryland Montgom	ery	Rockvill	.e			1反	Yes 2□No	
flar death with the Ma flar death with the Ma riner mast be notified funeral Director	10e. Street and Number		10f.	Zip Code		0g. Citizen of Wi			
m 23a	815 Woodley Driv		20850 Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (\$			United Sta			
D2(1 Never Married 2K Married	Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates:	if Yes,	specify Cuban, Mexican, Pue s 2 ☑ No Specify:	rto Rican, etc.)	Black, White, etc. Specify: White			
72 hours natural;	15. Decadent's Ec		16e. Decedent's U	Jsual Occupation	orking	16b. Kind ot Bus			
	Elementary/Secondary (0-12)	College (1-4or 5+)		work done during most of wo T use retired)	, and	-	nery Cour	ity	
	17. Fether's Neme (First, Middle, Last)	1	Library	Assistant	ame (First, Middle,		rnment		
Maryland 2 ad 2 should be filed v th and Mentel Hygie th is marked other traumatic avent, in To Be Co	Lloyd Decker				French		,		
S should and M and	19e. intormant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and Number or F		r, City or Town, S	State, Zip Code)		
fe, Ma t and 2 s Health ar Health ar Health ar Health ar Health ar	David E. Smith /H	usband	815 Wood	lley Drive, Ro	ckville,	Marylan	d 20850		
altimore, mil. Pages 1 al partment of Hea portant: If Nem; y Injury or others.	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremetion 3 ☐		 b. Place of Disposition (cemetery, crematory 	(Name of or other place)	Jan. 6,	20c. Location - C	City or Town, State	ð	
Liming Pag	4 Donation 5 Other (Specific	Mc		natorium, Inc.	2000 I		, Maryla		
Baltimore, In permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tights.	21. Signature of Funeral Service Licer	1	Rober 300 W	e and Address of Facility t A. Pumphrey lest Montgomer rille, Marylar	Funeral y Avenue	Home/Ro	ckville,	Inc.	
Physician /Medical	23a. Part1. Enter the disease, or com shock, or heart feilure. List only		batti. Do not onto the	mode of dying, such as cardio	ac or respiratory and	rest,	interval	Imate Between and Death	
Examiner	disease or condition resulting in death)	a	o (or as a consequence						
in ed		b							
58760, cate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due t	o (or as a consequenca	of):					
W = -= W	that initiated events resulting in death) Last	Due to	of):						
Box death cer e attendir of for use	Part ti. Other significant conditions of	ontributing to death but not	resulting in the underlying	no cause given in Part i.	23b. Did to	obacco use con	tribute to the cau	use of death?	
P.O. do by the detache	HABOLALEYORU				×	/		4 Unknow	
req red show					24a. Wes a perfor	an autopsy med?	24b. Were autop available po completion of death?	rior to	
The page					1 □ Y	es 20No	1 🗆 Yes	20 No	
of Vital I Physician: The this certificate ral director, page ral control of the	25. Was case referred to medical examiner?	Magnitai.			eath (Check only or	ne)			
Physic Physic al dire	12 Yes 2 No 27. Manner of Death			DOA Other: 4 Nursing	X	ence 8 Othe			
Division of Vital To the Mospital or Attending Physician: T within 24 hours after death. To the Funeral Director: After this certifical completaly filled in by the funeral director, p Medical Certification: To Be C	2 Naturel 5 Pending Investigation 3 Suicide 6 Could not be		М	Work? 1 ☐ Yes 2 ☐ No				Alumbas	
DIVI	4 Homicide determined	building, etc. (Sp			City or Tow	n, State)	er or Rural Route	vainou,	
Hospital 24 hours 6 Funeral 1 etaly filled				red at the time, date end pled tion, in my opinion, deeth occ				se(s)	
To the within 2 To the comple	29b. Signature and title of certifier	was. (9	OMF)	29c. License number 0 15 23L		29d. Date signed	(Month, Day, Yes	ar)	
10	30 Name and address of person who CMC I - WALGO'S.	completed cause of death (Item 23a) (Type, Print)	podaiut, h					
State	31. Dete tited (Month, Day, Year)	32. Pegistrar's S		no Kal					



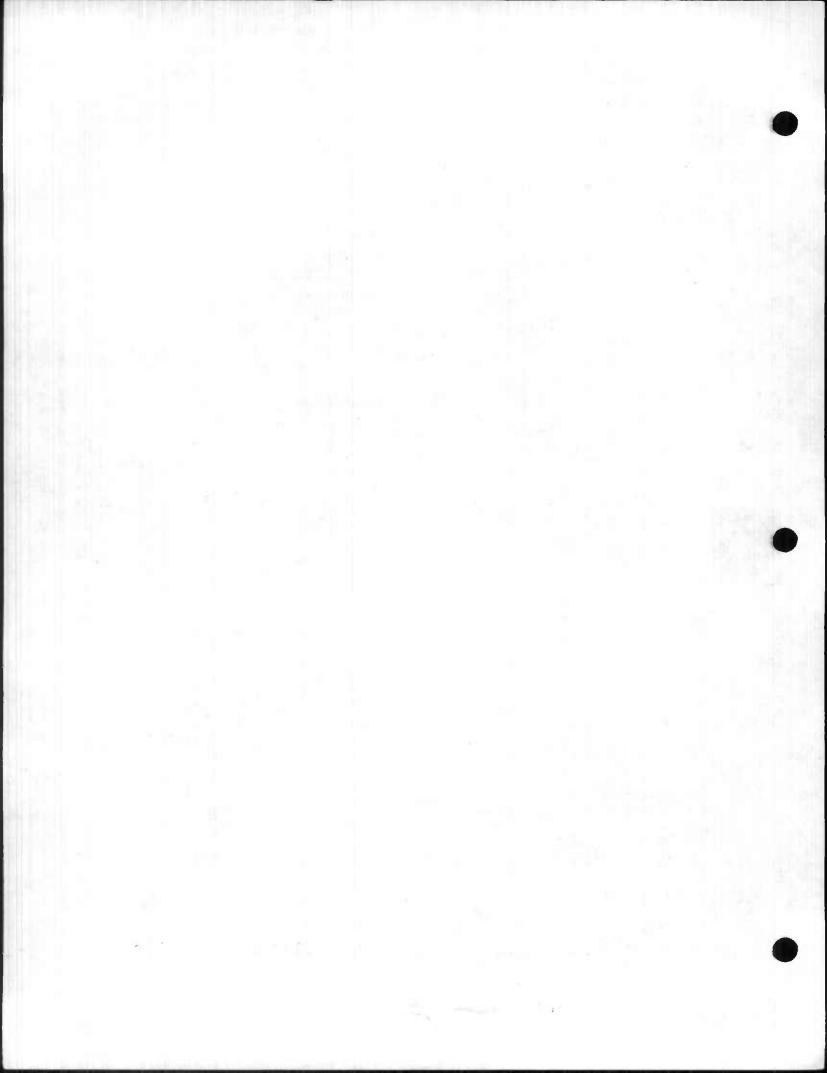
Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

01023 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death January 1,2000 **Physician** Ruth L. Sherrod 9:57 AM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20544 Amethyst Lane Germantown Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗓 F 190-20-2483 74 Director August 25, 1925 Pennsylvania **Usuat Residence of Decedent** Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahoa must be notified at Maryland Frederick Ijamsville 1 ☐ Yes 2 ☑ No Directo 28a-1 ŧ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŧ b harma 23a 11205 Jon Court 21754 United States Funeral death 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status r than "natural", or han the Medical Examiner Armed Forces? 72 hours after 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2⊠ Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens."n Elementery/Secondary (0-12) College (1-4or 5+) Reference Librarian College 5+ permit. Pages 1 and 2 should be illed Department of Health and Mental Hygi Important: If then 27 is marked other any injury or other traumatic event. the 17. Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumeme) e 2 Donald McMillan Virginia Trout 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Sherrod/Daughter 20544 Amethyst Lane, Germantown, MD 20874 Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Jan. 5, Silver Spring, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 Nother (Specify)Entombment Gate of Heaven Cemetery Maus. 2000 Maryland 21. Signature of Funeral Service License 22. Name and Address of FecilityRobert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00689 Rockville, Maryland and the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, the mode of dying. Such as cardiac or respiretory arrest, the mode of dying. M00689 Approximate Intervel Between Onset and Death Physician /Medical Immediete Cause (Finel disease or condition resulting in death) e Metastatic Renal Cell Carcinoma 2 years Examiner Due to (or as e consequence of): physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, certificate be Physician/Medical Due to (or es a consequence of) 8 880 0 P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 2⊠ No 3 Probably 4 Unknown signed t Records, p 24b. Were eutopsy tindings evallable prior to 24e. Wes an autopsy performed? Completed Deen completion of cause of death? page 2 s has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai director Be 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Daughter's Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 (XOther (Specify) Residence 2 1 Yes 20 No this After thi 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjuny at Work? Certification: i or Attending Fatter death. 1 XNeturel 5 Pending after death. Director: Aft investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours after Funeral Dire letely filled in b To the Hospital of within 24 hours af To the Funeral D completely filled is 1 Certifying Phyatcian: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Harry DC 19757 (3 00 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Michael J. Hawkins, M.D. 110 Irving Street, N.W., Washington, DC 20010-2975 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State souls JAN 0 4 2000 Registrar

DHMH 16 Ray 6/95

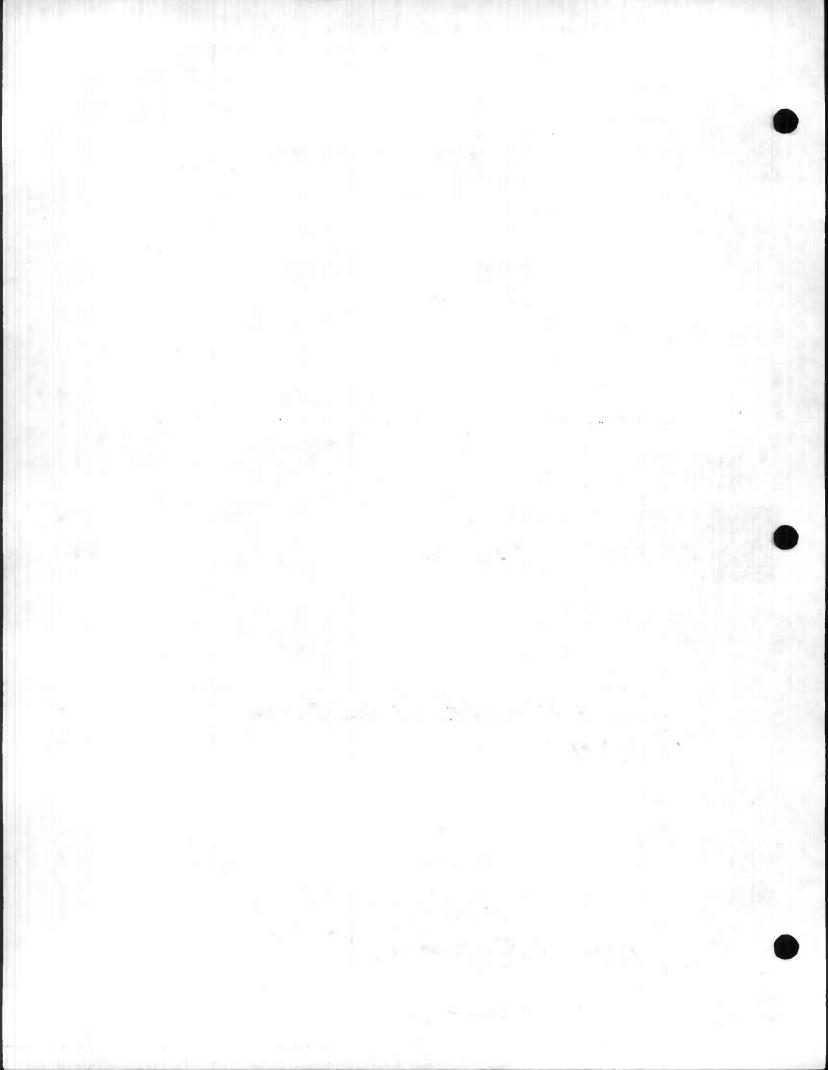


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 0 2 4

				(Certificat	e of	Death			Reg. No.	0 0	1064
		1. Decedent'a Name (First, Middle, Li	ist)						2. Date of Dea	ith	V	3. Time of Death
	Physician /Medical	James			Smi	th			Month January	Day 3, 200	Year)0	11:45 p.1
	Examiner	4a Facility Name (Il not institution, gir	ve street and number)				4b. City, To	wn, or Lo	cation of Death			
		CAREMATRIX OF SI	LVER SPRING				Silve	er Sp	ring	Montg	gomery	7
	Funeral Director	576-11-8113	Sex 7. Age (In yr. 1	s. last birthe Yr	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day March 29			ace (State or Foreign ry) n Islands
	2 2	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town	or Location						10	d. Inside City Limits
	or 28a-f sho ba.notified.a Director	Maryland Montgom			Spring							1□ Yes 2√ No
		10e. Street and Number 2700 Barker Stree				20910 Unit					What Count State	S
020	ar, or he Examine by Fu		12. Was Decedent Ever in Armed Forces? 1		13. Was Dece II Yes, spe		lispanic Ori an, Mexicar Specify:		city Yes or No- Rican, etc.)	14. Rad Blad Specify	e - America ck, White, e y: blac	itc.
5.0	72 ho fical	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Usu Give kind of wo	al Occup	ation	t of worki	20	16b. Kind of B	usiness/Indi	ustry
21215-0020	within the Man	Elementary/Secondary (0-12) UNAVAILABLE	College (1-4or 5+)	- 1	MAVAILA	se retire	d) ""()	i or works		UNAVAI	LABLE	
P	tal Hygi d other event, I	17. Father's Name (First, Middle, Last)				18. Mothe	r's Neme	(First, Middle,	Maiden Suman	10)	
Maryland	Ber 5	UNAVAILABLE					UNA	VAIL	ABLE			
lar	and and	19a. Informant's Name/Relationship								r, City or Town,		
	arid n 27	Sherry Seal(gua					ford	Dr.,	7			
Baltimore,	Pages Insert of H	20a. Method of Disposition 1 Burial 2 December 3 4 Donation 5 Other (Speci	Removal from State	cemetery,	oisposition (Na crematory or c eake Cr	other plac		NC.1	Dete /4/2000	Beltsv Maryla	ille,	m, Stete
Bait	Departition of the post of the	21. Signature of Funeral Service Ligo	MOO	0.50	22. Name a Rapp I Stephe	d Addre	ss of Facilities al & Lohn	Crem	ation S	Services	,	and 20910
	Physician /Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. Sept	Clu	(nsequence of)							Interval Between Onset and Death
68760,	death certificate be executed e attending physician and id for use as the buriel-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenity	c		nsequence of)							
Box 68	E 5	resulting in death) Last	d									
	d for	Part II. Other significant conditions of	contributing to death but not re	sulting in t	ha undarhina	euse ai	ren in Part I		23h Did t	obacco use co	ntribute to	the cause of death?
, P.O.		Belaterald	regrese ba	Pal	AURO	es	Hren	use	-	/es 2□ No		ebly 4 Unknown
Records,	been shoul	Dehidister	el .							an autopsy med?	ava	re autopsy findings illable prior to appletion of cause leath?
	The page								101	es 2 No	10	Yes 2⊠ No
VIta	ertific ector, Be	25. Was case referred to medical examiner?						of Death	(Check only o	ne)		
5	Physician: this certific ral director,	1 ☐ Yes 2 ☒ No		☐ ER/Outp	atient 3 D	-	452146			ience 8 Oth)
ion	Attending P in death. ector: After the by the funeral iffication:	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ne of ury M	28c. tnjur Wor 1 □	yat k? Yes 2□		28d. Describe h	ow injury occur	red	
Division	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not b	28e. Ptace of Injury - At building, etc. (Special	home, fem	n, street, lactor	y, office		1	281. Location (S City or Tow		per or Aural	Route Number,
	n 24 hospi n 24 houns ne Funer pletaly fill edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of my kn niner: On the basis of examination	amileign, o	deeth occurred or investigation	et the tir , in my o	ne, dete en pinion, dee	d place, e th occurre	end due to the o ed at the time, o	euse(s) and ma dete end plece,	anner as sta and due to	ated. the cause(s)
	Within To the Company	29b. Signature and title of certifier	4	,	29	c. Licens	e number	2/		29d. Date signe	d (Month, E	Jay, Year)
	3	30. Name and address of person who	completed cause of death (the	Cres /	VDe. Print)	10	001	4		January	7 4, 2	2000
		Myron L. Lenkin				d	Wheat	on. ¹	Marvlan	d 20902	-1825	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1		/					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** Catherine A. Seckar 1, 2000 January 1:50AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 X F Yrs. Director Dec. 31, 1922 Washington, DC 578-22-7469 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours efter deeth with the Merylen al Hyglene.
Other than "natural", or flems 23s or 28s-f ehow vent, the Medical Examine: must be notified at 1 N Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Valley Stream Drive Funeral 20851 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 XNo if Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pages 1 and 2 should be filled v. Department of Health and Mental Hygle. Importants: if item 27 is marked other the eny linjury or other treumatic event, the page. 12 Travel Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 2 Herman Forney Mary Ellen O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Valley Stream Drive, Rockville, Maryland 20851 of Disposition (Name of Date 20c. Location - City or Town, State Stephen Seckar/Husband 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan 2 4 ☐ Donation 5 ☐ Other (Specify) 2000 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signatura of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 M00803Rockville, Maryland 300 West Montgomery Avenue and 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis 2 Weeks Examiner Due to (or as a consequence of): Pneumonia physicien end s the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Urinary Tract Infection Physician/Medical Due to (or as a consequence of): 8 Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Encephalopathy (infectious vs. metabolic etiology) by 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24a. Was en autopsy 1 ☐ Yes 2 No 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA P 1 Yes 2 Wo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. ed by the e P.0. pege 2 should be de Records, certificate Division of Vital al or Attending Physicien: The setter death.

I Director: After this certificated in by the funeral director, pe e Hoepital or 24 hours eff e Funeral Di sletely filled in To the Hosp within 24 ho To the Fune completely fi

be executed

the Meryland

altimore, Maryland 21215-0020

15

State

Registrar

edical

29a. Certifier

(Check only one)

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of continue

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

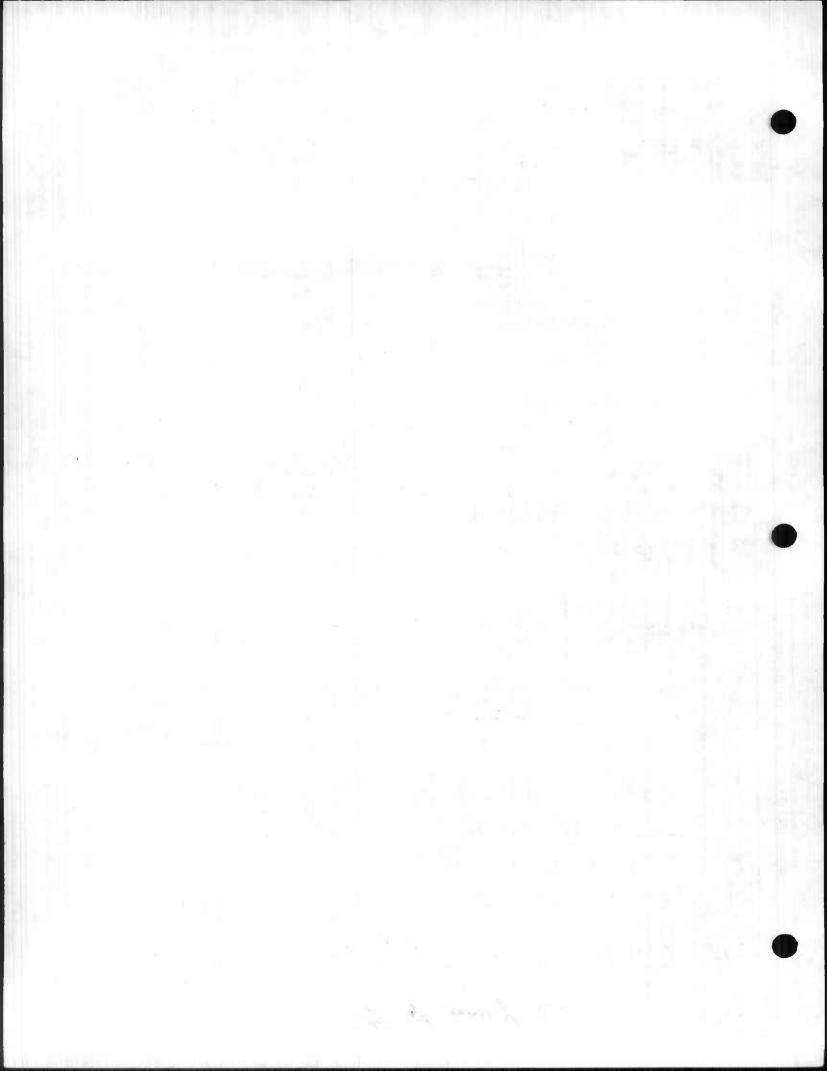
D0037620 January 1, 2000

30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Godec, M.D. Casey House, 6001 Muncaster Mill Road, Rockville, MD

31. Date filed (Month, Day, Year) JAN 03 2000

2 Medical Exam

32 Hogistrar's Signature

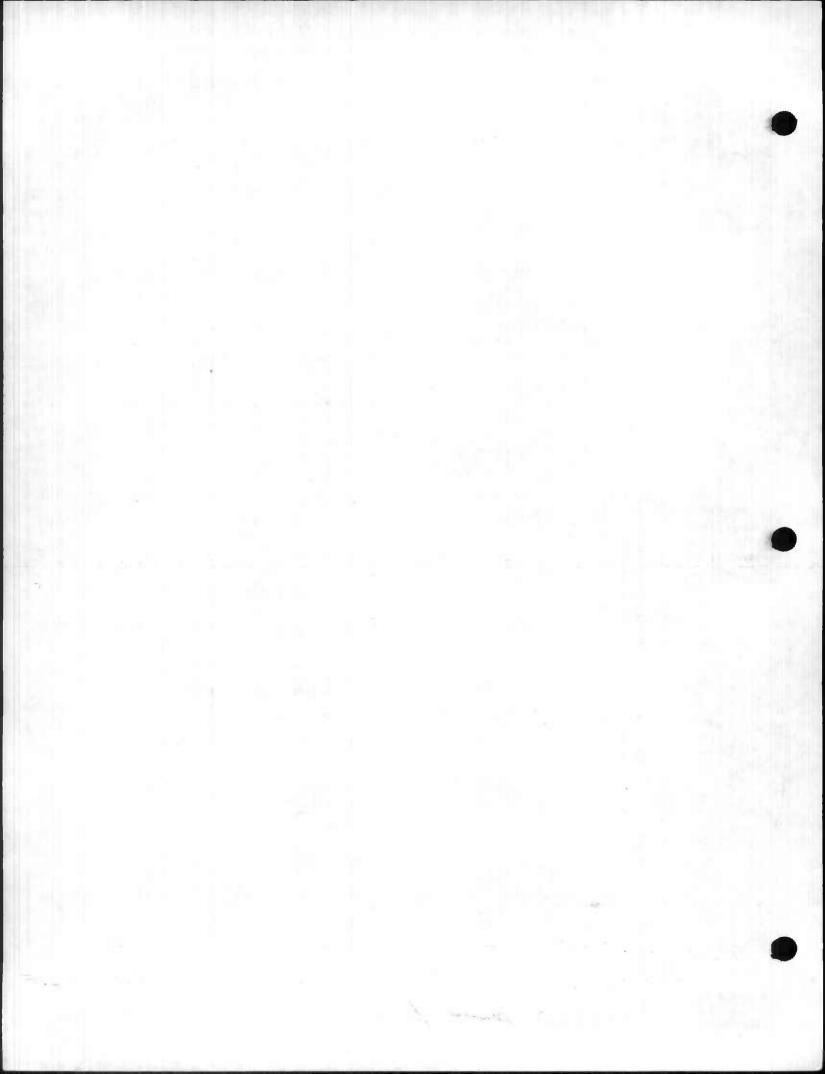


Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth 2 2000 Year **Physician** Month 6:20 AM RENA SCHWIEGER /Medical 4b. City, Town, or Location of Death 4a Fscility Name (If not Institution, give street and number) 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Dey, | 8-7-13 Birthplace (State or Foreign Country)
 GERMANY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2K) F Yrs. **Director** 86 065-24-3648 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show VIENNA VA FAIRFAX No Yes 2 No Director 288-71 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 22182 USA Barra 23a 10202 YELLOW PINE DR. Funeral t 4. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after b 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give altimore, Maryland 21215-0020 1 Ves 2 No Specify: Specify: WHITE 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING BOOKKEEPER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fit Department of Health and Mertal Hy Important: if feen 27 is merited oth any injury or other trearmatic event once. Be ISAAC FUND BERTHA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10202 YELLOW PINE DR, VIENNA, VA 22182 GRANDSON SETH WEINGAST 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🏋 Removal from State LONG ISLAND, NY 1-3-2000 BETH MOSES CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC, Hoseld W. Riverbus 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final GANGRENE RIGHT disease or condition resulting in death) Examiner PERIPHERAL VASCULAR

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSIVE Box 68760, CARDIOVASCULAR Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobecco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 ⊠ Unknown HRTERY DISEASE Records. Ag 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law page 2 : 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Desth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature and Affle of certifier 29c. License number Lapson MD 02/00 30 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) LIPSON MONTROSE ROAD, ROCKVILLE 31. Date filed (Month, Dey, Year) 32. Hagistrar's Signature State books Registrar JAN 0 4 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month January 4, 2000 Georgiana Buddeke Twomey 5:00 am 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver Spring Mont; H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month, Pay, Year) Dec 14, 1906 Bedford Court Nursing Home Montgomery 5. Sociel Security Number 9. Birthpleca (Stete or Foreign Country) Ohio 6. Sex 7. Age (In yrs. lest birthday) 1 M 2 F 93 Yrs. 220-28-5607 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2√ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 15101 Interlachen Drive USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: 11. Meritei Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien. Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Administrative Assistant Banking 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John A. Buddeke Ruth Murray 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ruthann T. Arnsberger/Daughter 9619 Bristol Avenue, Silver Spring, MD 20901 20e. Method of Disposition 1 ♣ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Gate of Heaven Cemetery 1/8/2000 Silver Spring, MD 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 21. Signature of Foresal Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximete Intervel Between Onset end Deeth Immediate Cause (Finel Colon Cancer 4 years disease or condition resulting in deeth) Due to (or es e consequença of): Due to (or es e consequence of): Due to (or es e consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Anemia 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

Physician /Medical Examiner

-transit

and

physician

be del

certificate

After

death.

after death

To the Hospital or within 24 hours aft To the Funeral Discompletely filled in

Box 68760.

P.O.

Records.

Division of Vital or Attending Physician: Examiner

Physician/Medical

by

Completed

Be

9

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

ò

Completed

Be ပ

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Wedical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 ia marked other than "natural", or ther any injury or other traumatic event, an Medical Examina

Baltimore, Maryland 21215-0020

the Maryland

death

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

Hypertension

1 Yes 2 No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1 Yes 2 No

Vementra

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 28d. Describe how injury occurred 1 Yes 2 No

2 Accident investigetion 6 Could not be determined 3 Sulcide 4 - Homicide

28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

D31918

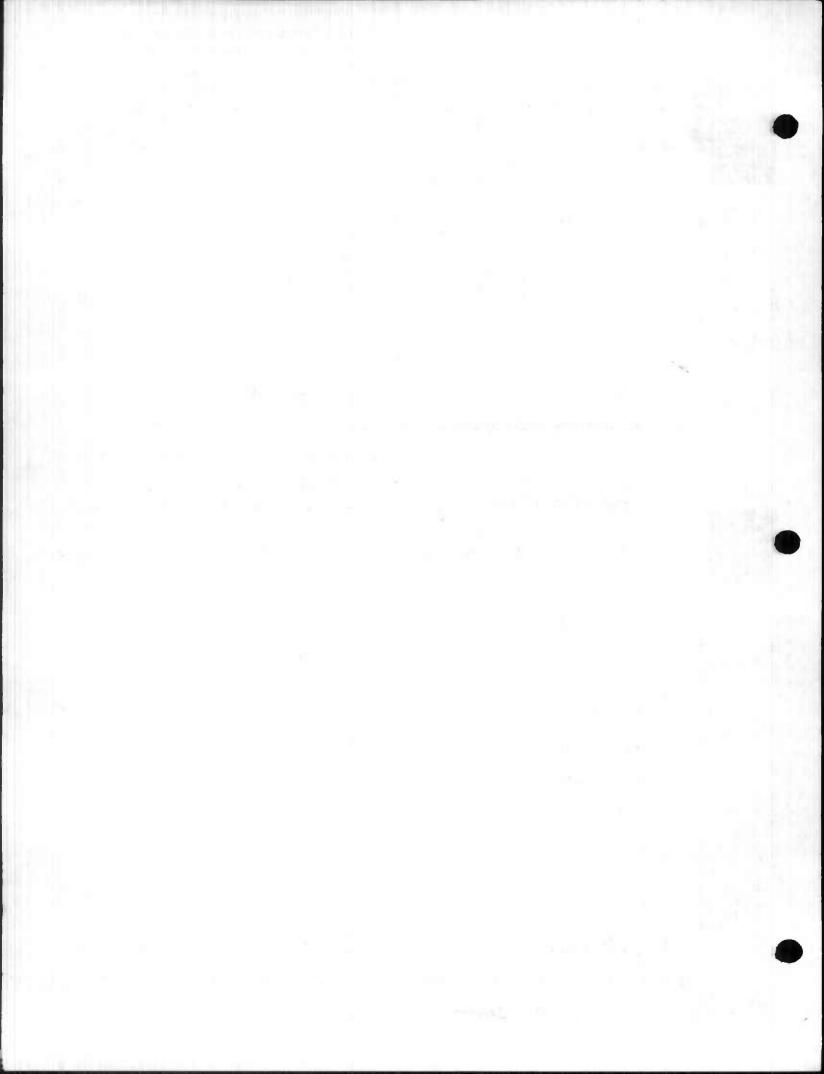
JANUARY 4, 2000

WARREN). FERMS MA, 3305 NORTH LEISURE WORLD BOSLEVARD SILVER SKING MALYLAND 31. Dete filed (Month, Day, Year)

JAN 0 7 2000

32. Begistrar's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day 1, 2000 Kermit Martin Trigg January 6:45 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) Hours Vrs 088-18-9777 3,1902 Washington, D.C. Nov. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥ Yas 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1701 Alberti Drive 20902 United States 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 20 No If Yes, Give Year or Datas: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph Trigg Cora Martin 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice B. Trigg, wife 1701 Alberti Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ABurial 2 Cremation 3 Removal from State 5 Office (Specify) Gate of Heaven Cemetery 4 Donation 1/8/00 Silver Spring, MD A Fundral Socios Licos 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 2 days Dua to (or as a consequence of): Prior Cerebrovascular Accident 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Examiner or Attending Physician: The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, this To the Hospital or Attend within 24 hours after deal To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

28e-f

must be n

8

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.

Hygiena.

nt of Health a H Item 27 is or other tra

Physician

/Medical

the

for use as

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

filled in by

completaly

12

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

Be

aı	t II. Other stgnificant conditions o	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23b. Did tobecco use co 1 ☐ Yes 2∑ No	ntribute to the cause of death? 3 Probably 4 Unknow
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 No
25.	Was case referred to medical			26. Place of D	eath (Check only one)	
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Oth	er (Specify)
7.	Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of tnjury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
	3 Suicide 6 Could not b determined		nome, farm, street, fact	ory, office	281. Location (Street and Numb City or Town, State)	per or Rural Route Number,

29c. License number

D0023271

State Registrar

Michael Frais 31. Date filed (Month, Day, Year) JAN 0 6 2000

29b. Signature and title of certifier

Norgyma

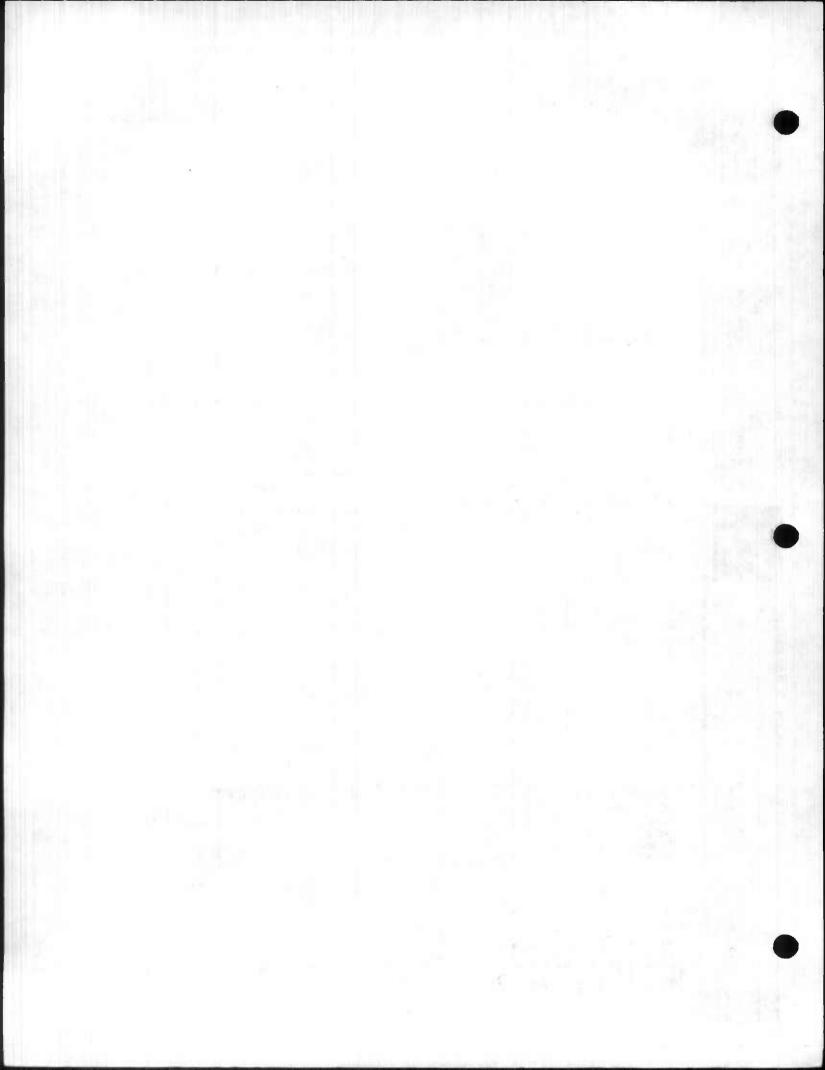
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

13975 Connecticut 32. Registrar's Signature

#308 Silver Sirmy, MD

29d. Date signed (Month, Day, Year)

20906



State of Maryland /	Department	of Health and	Mental Hygiene

Months

10c. City, Town or Location

OLIVIA
THOMAS
Dhusisian

Certificate of Death 1. Decedent's Name (First, Middle, Last)

Reg. No. 2. Date of Death

4c. County of Deeth

3. Time of Death

10d. tnside City Limits

Yes 2 No

Physician
/Medical
Examiner

OLIVIA THOMAS K.

JANUARY 4b. City, Town, or Location of Death

2000 2:51A.M.

Funeral Director

> 25a-f show must be notified at

8

Items 23s

b

filed within 72 hours after

Pages 1 and 2 should be Ill ment of Health and Mental H lant. If hem 27 is marked off

21215-0020

Maryland

altimore,

68760.

Box (

P.O.

Division of Vital Records,

Directo

Funeral

à

Completed

I-95 AT I 895 5. Sociel Security Number 7. Age (In yrs. last birthdey) 6. Sex 1□M 20 F 7 Yrs 220-35-7167

Ellicott City HOWARD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | June 26, 1992 9. Birthplece (State or Foreign

Usual Residence of Decedent 10a. State

10b. County Wake

4a Facility Name (If not institution, give street and number)

Wash.

N.C.

Garner

10f. Zip Code 27529 10g. Citizen of What Country?

10e. Street and Number

308 Tensaw Court 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Rece - American Indian, Bleck, White, etc.

Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

Specify: 16a. Decedent's Usuel Occupation

Specify: Black 16b. Kind of Business/Industry

U.S.A.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12) 2 nd College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired) Student

1 Yes 2 No

Education

17. Father's Name (First, Middle, Last)

Ed Thomas

Paula Mickens

18. Mother's Neme (First, Middle, Meiden Surneme)

19e. Informent's Neme/Reletionship (Type, Print) Paula M/ Grange (Mother)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 308 Tensaw Ct., Garner, NC

20a. Method of Disposition

1 ☐ Buriel 2 ☐ Cremation 3 🖾 Removal from Stete

20b. Plece of Disposition (Name of cemetery, cremetory or other place) Haywood Funeral Hm.

20c. Location - City or Town, Stete Dete

4 ☐ Donetion 5 ☐ Other (Specify)

1/5/00 Raleigh, NC

21. Signature of Funeral Service Licensee

23a. Pert1. Enter the Useese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latiture. List only one cause on each line.

22. Name end Address of Fecility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD

Physician /Medical Examiner

I or Attanding Physician: The law requires that the death certificate be associated after death.

Director: After this certificate has been signed by the attending physician and in by the Innertal director, page 2 should be deteched for use as the buriat-transit of in by the Innertal director, page 2 should be deteched for use as the buriat-transit

Examiner

Completed by

Be

edical Certification: To

filled in by

3

To the Hospital owithin 24 hours a To the Funeral D

Neck Injuries Due to (or es a consequence of):

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medical

Immediate Cause (Final

disease or condition resulting in deeth)

Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy

24b. Were eutopsy findings available prior to completion of cause of death?

Approximete Interval Between Onset and Death

26. Place of Deeth (Check only one)

performed?

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Menner of Death 5 Pending investigetion

6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 1/1/2000

28b. Time of Injury 216 A

STREET

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify SCENE 28d. Describe how injury occurred

PASSENGER IN METER VEHICLE ACCIDENT

28f. Location (Street end Number or Rurel Route Number, City or Town, State) I95 SWITH AT I-895

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Sulcide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Dete signed (Month, Dev. Year)

JANUARY 2,2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

JACK M. TIMS. 31. Date filed (Month, Dey, Year)

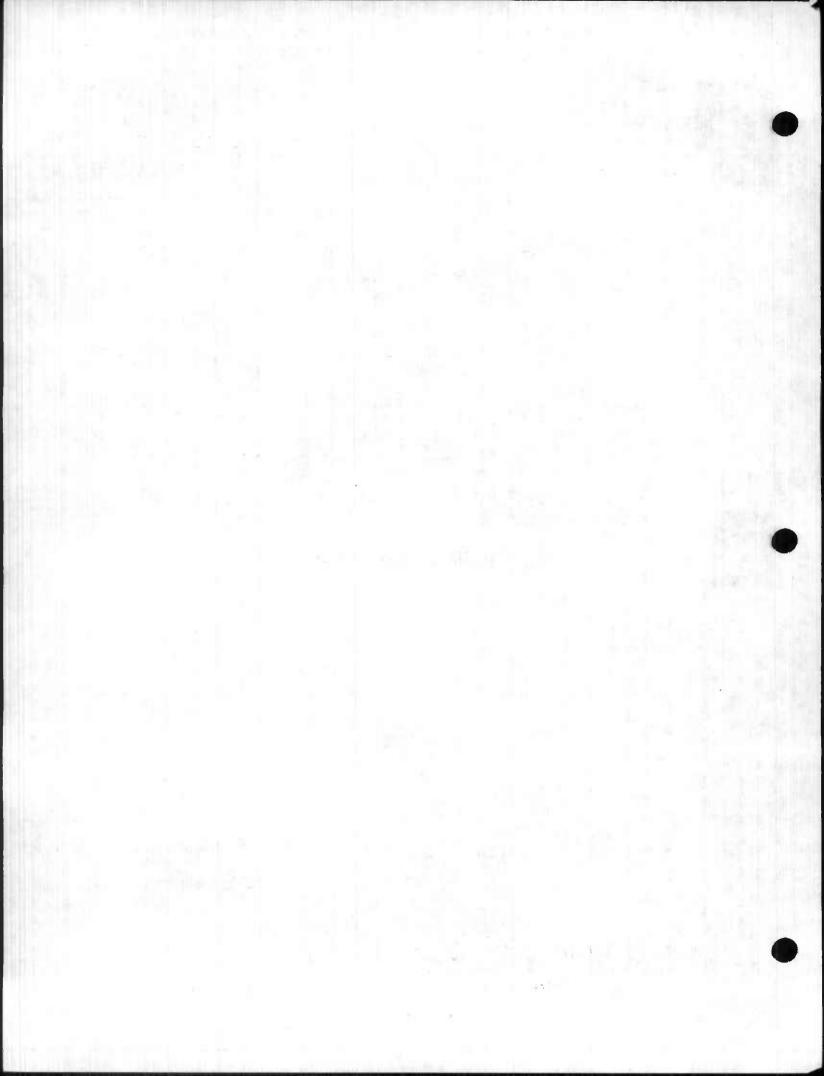
32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201

State Registrar

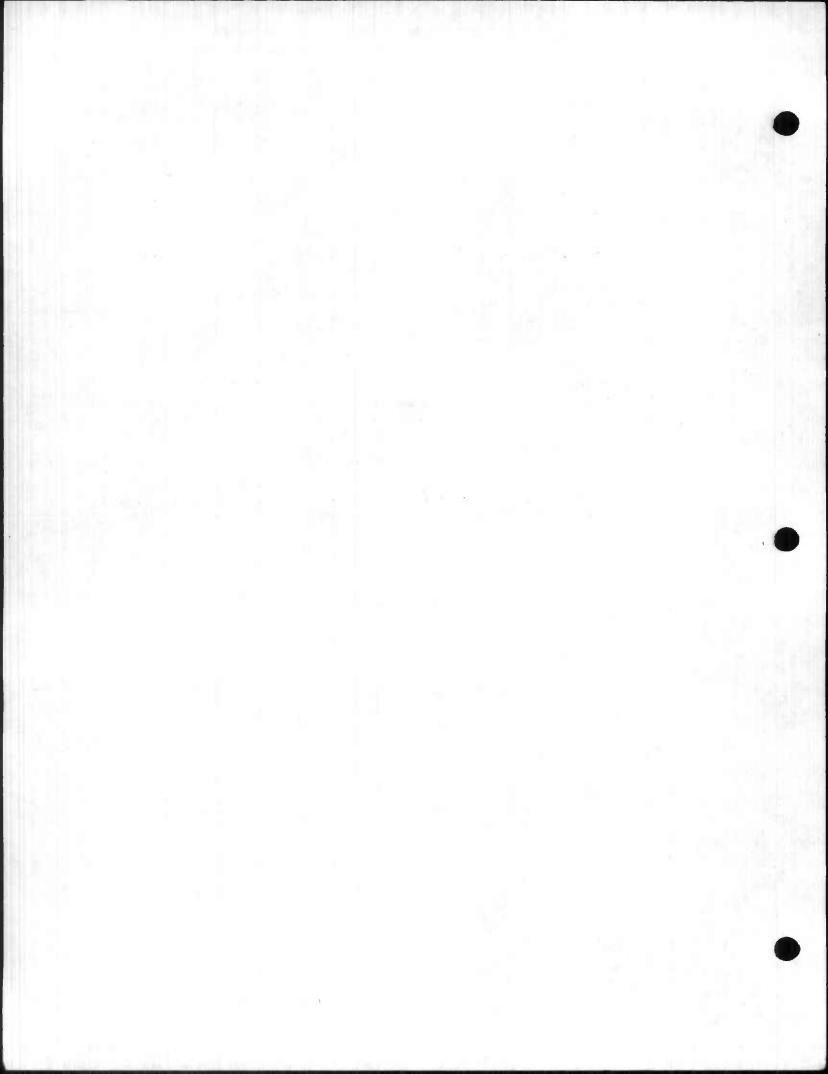
JAN 05 2000

Mia



Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible.

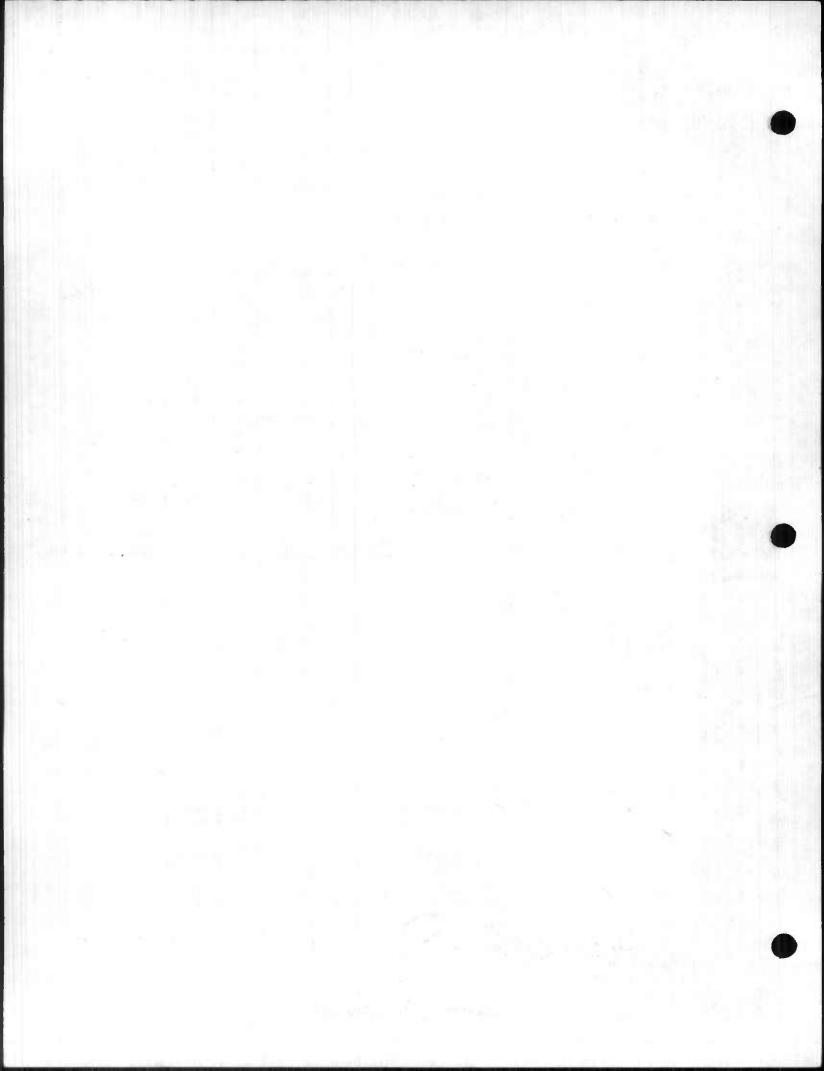
_	Decedent's Neme (First, Mid	tle (ast)		C	ertificate	of	Death	2. Date of De	Reg. No.	3. Tima of Death
Physician	Digna Torre	A COLOR						Month	Day Ye	7:20 AM
/Medical	4a Facility Name (If not instituti		umber)				4b. City, Town, or L			
Examiner	Suburban Hos		,				Bethesda		Montgon	
Funeral Director	5. Social Security Number Unknown	6. Sex 1 M 2 F	7. Age (In y	rs. last birthda Yrs.	Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi		Birthplace (State or Foreign Country) Colombia
	Usual Residence of Decedent							T-F-		0020111020
The Maryland 28e-f show solified at ector	10a. State 10b. County 10c. City, Town or Location Washington, D.C.									t 0d. Inside City Limits Y Yes 2 □ No
or 28ef a be notified	10e. Street and Number	-			10f. Zio C	code			10g. Citizen of Wha	t Country?
the of the	5201 Connection	ut Ave. N	.W. #2	01		2	0015		U.S.A.	
72 hours after death with the Maryte natural; or there 23e or 28e.f sho stell Examiner must be notified at sted by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	rried 1 Yes	2 2 No	1 U.S. 1	3. Was Deceder If Yes, specify 1 X Yes 2 D	nt of H y Cube	lispanic Origin? (Sp an, Mexican, Puerto		14. Race - / Black, V	American Indian, White, etc. Hispanic
than ball	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed College	ducation ade completed) College (1-4or 5+) 16a. Decedent's Usual Oc. (Give kind of work do life. DO NOT use rel HOUSEWIÍ				during most of world)	king	16b. Kind of Busin	ess/industry Ukn
	17. Father's Neme (First, Middle	. Last)			nousew.	116		e (First, Middle	, Maiden Sumame)	
uld be Mental inhad o dic eve	Celso Rodriqu							sa Belti		
and 2 should be file sellth and Mental Hy n.27 is mental doth er traumatic event	19e. Informant's Name/Relation Ruth Diaz	ship (Type, Print) / daughte	er						per, City or Town, Sta 201 Washi	ngton, D.C.20
permit. Pages 1 and 2 Department of Health 1 Important: if less 27 il any Injury or other tra	20a. Method of Disposition 1 D Burial 2 Cremation 4 Donation 5 Other		n State	cemetery, c	sposition (Name rematory or other	er plac		Date 01/06/00	20c. Location - City	or Town, State
permit. 7 Departm Importar any injur	21. Signature of Funeral Service				22. Name end	Addre	ss of Facility W	H. Baco	on Funeral	Home
	23a. Part1. Enter the disease,								ngton, D.C	20010 Approximate
Physician /Medical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in deeth)	a	Pne	umonia	sequence of):					Interval Between Onset and Death
ficete be executed the physician and the buriel-transit set the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S 6.	Due to	o (or as a cons	sequence of):					
	that initiated events resulting in death) Last	L	Due to	(or as a cons	sequence of):					1
d for d for	Part It. Other algniftcant condit	iona contributing to	death but not	neculting in the	a underhing cau	iso div	ren in Pert t	23h Did	tobacco usa contri	buts to the cause of death'
d by the detache	Dementia	to the contributing to	death but not	iosoming at the	onconying cac	Jao giv	or with oil t.			Probably 4 Unknow
The law requires that the detailer has been signed by the page 2 should be detached Completed by Physic									s en autopsy 2 ormed?	4b. Were autopsy tindings available prior to completion of cause of death?
The page								10	Yes 2 No	1 ☐ Yes 2 ☐ No
Physician: The law this certificate has al director, page 2: To Be Comp	25. Was case referred to medic examiner?	al					26. Place of Dea	th (Check only	one)	
Physician: Tribis certificate and director, per To Be Co	1 ☐ Yes 2 No	Hospital:	Mnpatient 2	□ ER/Outpat	tient 3 DOA	Oth	ner: 4 Nursing H	ome 5 Res	idence 6 Other (Specify)
or Amending Physical or Amending Physical Director: After this od in by the funeral of Ertification: T	Z L MUCIOSIII	tigation	e of Injury onth, Day Year	28b. Time Injur	of 280 y M	c. Injur Wor	y at rk? Yes 2 □ No	28d. Describe	how injury occurred	
tal or Attending P is after death. al Director: After t led in by the funer: Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b	29a. Cartifier 1X Certify (Check only one) 1 Medica	Examiner: On the	ne best of my libasis of examiner steted.	mowledge, de ination and/or	ath occurred at investigation, in	the tim	ne, date and place, pinion, death occur	and due to the	cause(s) and manne, date end plece, and	er as stated. I due to the cause(s)
To the To the Comp	29b. Signature and title of certifi				29c. l	Licens	e number		29d. Date signed (A	fonth, Day, Year)
3	▶ Atlatha	M M D			Do	05	3615		January 4	2000
	30. Neme and address of person									
	A. Nathan, M				al Lane	Su	ite 409	Rockvil	lle, Md.	
State Registrar	31. Date filed (Month, Day, Yea.		Registrar'a Si		Spar	Ks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Angela Mary Talley January 3, 2000 6:26 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. Birthplaca (State or Foreign DC Country) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) NOV 20, 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 80 Yes 577-14-5847 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring eug 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 2 with 20902 11703 Hatcher Place USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ⑤ No If Yes, Giva Year or Dates: Петв Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after d
Chartment of Health end Mentel Hygiene.
Important if them 27 is marked other than "natural", or hen
my frilux or other traumatic event, in a stad call and na 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 20 Vincent Campanella Carmela Romanazzi 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Marie Elden/ Daughter 9308 Palmer Place, Laurel, MD 20708 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Fort Lincoln Cemetery 1/6/2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Mcenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 from sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seuse on each line. 25a Bartt, En Approximate Interval Between Onset and Death Physician Troonic Rospington Failure /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be axecuted the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) P.O. Box 68760. Due to (or as a consequence of) for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown y herteritan Records, p should be d 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: '24 hours efter death. Funerei Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 € Inpatient 2 □ ER/Outpatient 3 □ DOA funerai 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1. Netural 1 Tyes 2 □ No 2 Accident filled in by the 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh C. Gupta, M.D. 4701 Randolph Rd., Rockville, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JAN 0 4 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

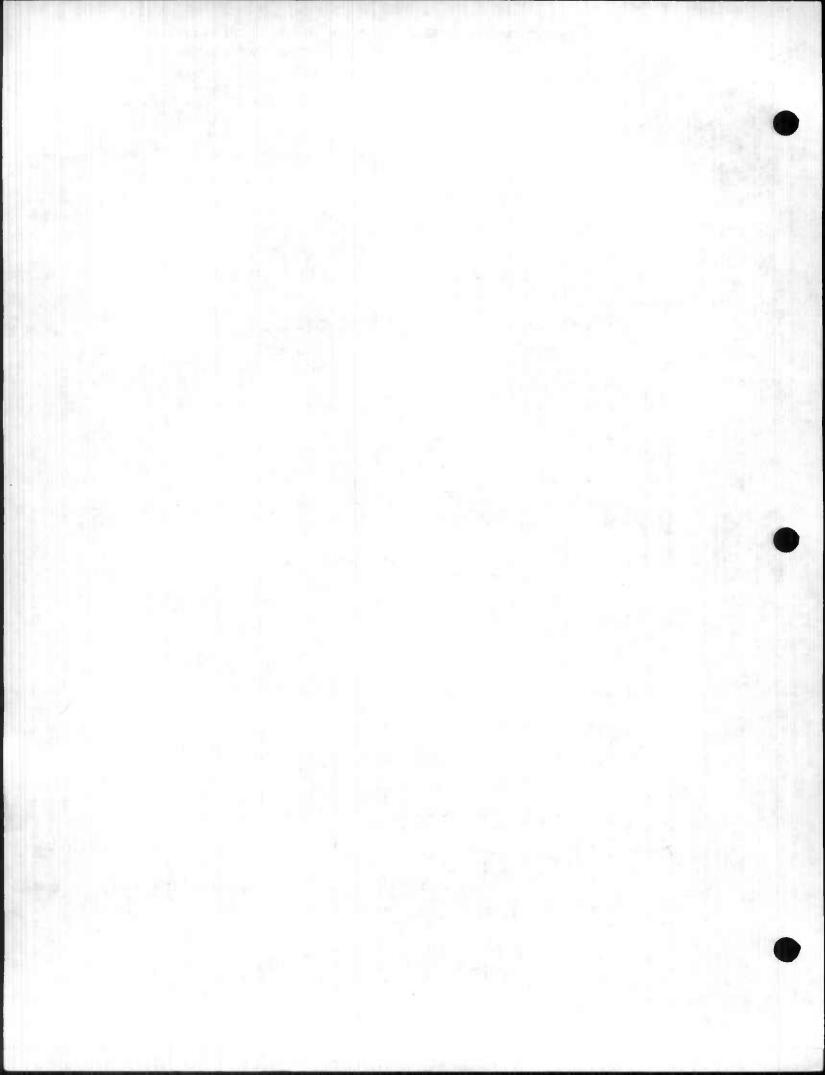
State of Maryland / Department of Health and Mental Hygiene

е	00	01	0	2	1
	9.0	UI	13	0	6

Certificate of Death 1 Decedent's Name /First Middle Last 2. Dete of Death 3 Time of Death **Physician** ED. Τ. THOMAS JANUARY 1, 2000 0323 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE SHOCK TRAUMA UNIT 8. Date of Birth (Month, Dev. Year) Nov. 18,1964 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F 35 Yrs Trinidad/Tobago 085 62 1877 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiere. other than "natural", or hems 23s or 28s-f show vent, the Medical Examiner must be notified at the Maryla N☐ Yes 2☐ No Directo Maryland Montgomery Village Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20879 United States 20003 Wolfdale Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Sfetus filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Manager Information Tech. Div. Bell Atlantic 5+ 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be next of Health and Mental Edwin C. Thomas Una D. Gaskin 10 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health I It fram 27 h Brian Thomas 2406 Mistletoe Pl., Adelphi, Maryland 20783 (Brother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, State Dete 20 1 Burlel 2 ☐ Cremetion 3 ☐ Removei from Stete Department of important: If any Injury or once 4 ☐ Donetion / 5 ☐ Other (Specify) George Washington Cemetery 1/8/00 Adelphi, Maryland 22 Name and Address of Facility
McGuire Funeral Service Inc. 21. Signature of Euneral Service Licensee 7400 Georgia Ave., N.W., Washington, D.C. 20012 23a. Part I Effect the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, about or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical HEAD AND NECK INJURIES Examiner Due to (or as a consequence of) Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as e consequence of) The law requires that the death certificate be exe P.O. Box 68760, Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown À of Vital Records, 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? **page 2** cartificate has Yes 2 No 2 No Physician: 88 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXVes 201No 2 ER/Outpatient 3 DOA Ser. 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred a Hospital or Attending Pt n 24 hours after death. Se Funeral Director: After it olestelv titled in by the funeral 27. Manner of Deetl 28b. Time of Division 1 Netural 2 Accident 5 Panding Injury 1 2000 0216 AM 2 No 1 Yes DRIVER IN MITTY VEHICLE ACCIDENT investigation 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) ISSSAIN AND IS95 28e. Piece of Injury - Af home, farm, streef, fectory, office building, etc. (Specify) 4 Homicide STREET To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. JANUARY 1, 2000 30. Name and address of berson who completed cause of death (item 23a) (Type, Print)

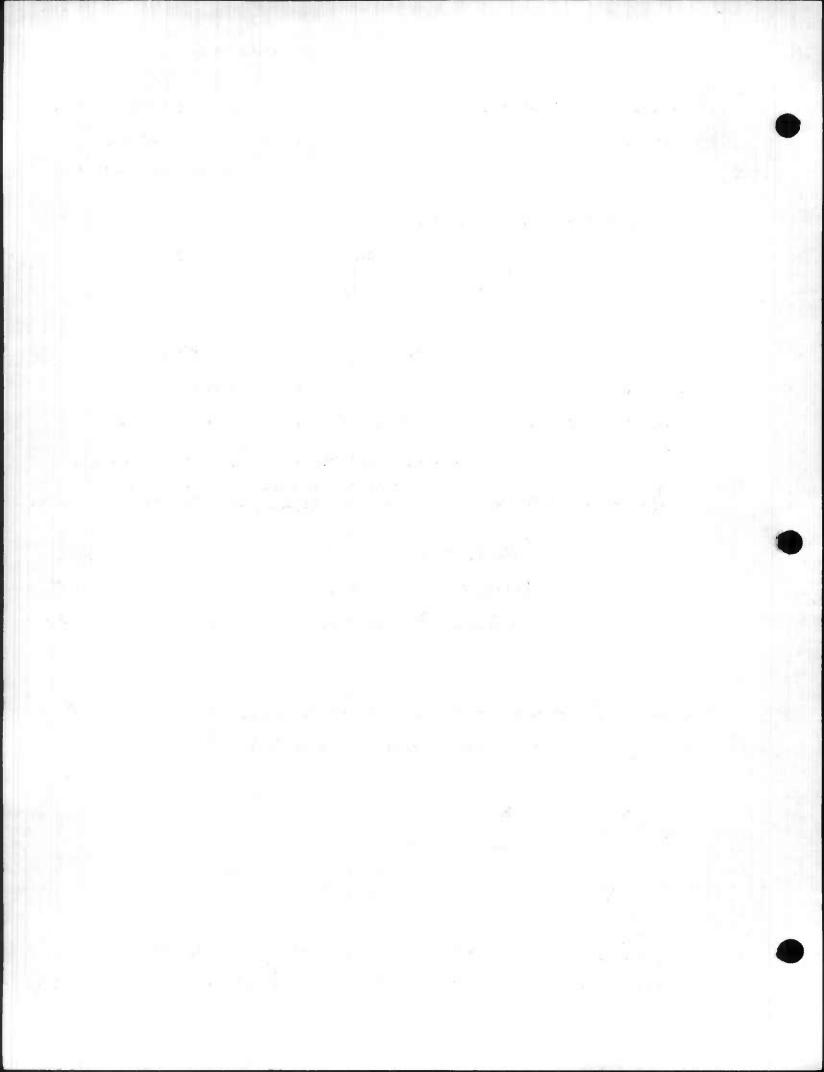
JPCK M. TMS, M.D. 111 Penn St JAK M. TIMS 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 05 2000 souks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	1	0	0	2
U	1	U	0	0

					1	Cer	tificate of	Death	R	eg. No.			
	Dhamini		1. Decedent's Name (First, Middle, Last))					2. Date of Dear	-	Vaar	3. Time o	of Daath
Physician /Medical			Christian Michael		January 3, 2000				11:0	0 am			
Examine			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of										
11551111			Holy Cross Hospita	ı 1				Silver Sp	ring	Montgo	mery	1	
	Funeral Director		N/A	x 7. Age	(In yrs. last bi	rthday) Yrs.	Months Days		8. Date of Birth (Month, Day) Dec 27	Year)	9. Birthpl Count (ary 1	lace (State try) .and	or Foreign
	fand fand		Usual Residance of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				T10	0d. Instde C	City Limits
	the Maryland 7 28a-f show notified at	tor	Maryland Prince Ge	eorge's	Hyatts	svil	le					1 ☐ Yes	No No
	th the	Director	10e. Street and Numbar				10f. Zip Code		1	0g. Citizen of W	hat Coun	try?	
	th will		2013 Pelden Road				20783		Ţ	JSA			
20	be filed within 72 hours efter death with the Maryland lail Hyglene. d other than "naturs!, or items 23a or 28a-f show event, the Wod call Exercine must be not lined at	by Funeral	11. Marital Status 1	12. Was Dacedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	ver in U,S.		/as Decedent of Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		, Whita, e		
5-0020	hour turs!		15. Decedent's Edu	Year or Dates:					16b. Kind of Bus	*****			
21215	filed within 72 Hygiene. ther than "na ont, the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e complatad) College (1-4or 5-	+)	(Giva k		e during most of working		N/A	1116 33/111Q	ustry	
	Hygi Hygi ont, p	C	17. Father's Nama (First, Middla, Last)		147	7 21		18. Mothar's Nam		ddle, Maidan Sumame)			
aryland		To Be	David Pugh					Christin	e Vicen	cio	,		
ary	A DEE	-	19a. Informant's Name/Ralationship (Ty	pe, Print)	195	. Maiting	Addrass (Stree	t and Number or Rur			State, Zip	Code)	
≥		١.,	Christine Vicencio	/ Mother	20	013	Pelden 1	Road, Hyat	tsville	, MD 207	783		
Itimore,	of Healt		20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ R	lamanal from Chata	20b. Place o	f Dispos	ition (Name of atory or other pla	ace)	Date JAN 5	20c. Location - C	City or To	wn, State	
Ĕ	Pages ment of I ant: If Ite ury or of		4 Donation 5 Other (Specify)				eaven Ce	J		Silver S	Sprin	ig, MI)
Balt	pemit. Pages 1 an Depertment of Heal important: If Item 2 any Injury or other once.		21. Signature of Funeral Service License	90		22. Fr	Name and Addr	-				0,	
	20.5 6 8		Lames & Oc	solez .		50	O Unive	reity Blue	. W. Si	lver Sni		MD 2	20901
			23a. Part Entar the disaasa, or compti shock or heart failura. List only on	cations that caused in	tha death. Do	not ente	r the mode of dy	ing, such as cardiac	or respiratory arm	est,		Approximation	te tween
	Physician		Immediate Course (Size)	0							- 3 :	Onset and	Death
	/Medical Examiner		Immediate Causa (Final disaase or condition rasulting in daath)	INWM	JUDILA	X						3 HR	S
	155/1	er	,		Dua to (or as a	consaqu	,	-				2 20	Œ
	uted	Examiner			Dua to (or as a		overtice	€				2 1)A	0
ń	executed in and hal-transil	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury					T) C			-	7 DA	rc
98760	death certificete be executed e ettending physician and yd for use as the burial-transit	edical	that initiated events	ex They	ue to (or as a	Ren	. , .	Υ			-	1 1	5
	ng ph	Med	resulting in death) Last								- 11		
ROX	eath cer ettendir for use		d	l							-		
	m _ C @	Physician/	Part II. Other algnificant conditions con	tributing to death but	t not resulting in	n the un	derlying causa gi	ven in Part I.	23b. Did to	bacco uae conf	ribute to	the cause	of death?
J.	E >0	Phy	overma Memora	NOTE IN	RASTE		CARITA	1 A. TODONTO	1 TY	0a 2□ No	3 🗆 Prob	ably	unknown
ŝ	signe bed	by	OKTICENTO 1 WIN	1	-10	N. CC	C. 4-0 (H	- 100100111					
Hecords,	ie faw requires that hes been signed b ge 2 should be deta	Completed	SHOCK Pums	way HE	mar-1-	MG	E Thor	Bocroper	24a. Was a perform		ava	ra autopsy nilable prior npletion of d death?	to
	는 등 원	Con							1 □ Y€	s 22Wo	1 🗆	Yas 2	No
VITa	Physiclen: Th this certificate ral director, per	Be	25. Was casa raferred to medicat examiner?	fospital:			100	26. Place of Deat	h (Check only on	a)			
0	this aldi	. To	1 Yes 2 No	1 0 Inpatian			3LI DOA		me 5 Reside)	
0	After funer	ertification:	1 Naturat 5 ☐ Panding	28a. Date of Injury (Month, Day		Time of Injury	28c. Inju Wo	rk?	28d. Describe ho	w injury occurre	ru .		
DIVISION	Attender death ector:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Placa of Injur	rv - At home, fa	arm, stre		7,00 2,00	28f. Location (St	reet and Numbe	r or Rural	Route Nun	nber,
S	al or Attending F s after death. I Director: After of in by the funer	Cert	4 Homicide	building, etc.	(Specify)				City or Town				
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	edical (29a. Certifier (Check only one) Certifying Phya Medical Examin	alcian: To the bast of her: On the basis of a and manner stat	axamination an	e, death	occurrad at the tiestigation, in my	me, date and place, opinion, daath occur	and due to the cared at tha tima, di	ause(s) and man ata and placa, a	nar as sta nd due to	ated. the causa(s	s)
29b. Signatura and title of cartifier 29d. Date signed						9d. Date signed	(Month, E	Day, Year)					
			1/1/1/1	1 _~~	พก		1)2-	0524		3/00			
	1	}	30. Name and addrass of person who co	1	1/	(Type, P				10100			
			STEVEN P. WYNOT		164 d			1500 01	CEST GL	en RD	SILV	a spai	my m
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatura	4	Spark	2/		,			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		eg. No.	0 01034					
Physician	Decedent's Name (First, Middla, Last)	2. Date of Dea Month	Day	3. Time of Death					
/Medical	SANDRA L. WILSON	JAN.	-	00 8:50 PM					
Examiner		vn, or Location of Death	4c. County						
P		ham	PRINC	E GEORGES					
Funeral Director	5. Social Security Number 218-54-8722 6. Sex 1 Months 7. Age (In yrs. last birthday) 49 Fig. 1 Under 1 Year Months Days Hours Usual Rasidence of Decedent	ham 4 Hrs. 8. Date of Birth (Month, Day Apr.	26,195	Birthplace (State or Foreign Country) Maryland					
land w	10a. State 10b. County 10c. City, Town or Location	•		10d. Inside City Limits					
the Marylan r 28a-f show notified at	MD Pr. Geo. Greenbelt			12€ Yes 2 □ No					
of terms and the maryland the maryland the mast be notified at the mast be notified at Funeral Director	10e. Street and Number 6231 Spring Hill Dr., #102 10f. Zip Code 20770	1	0g. Citizen of V	That Country?					
or Its	11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Original If Yas, specify Cuban, Mexican, If Yas, Signer Specify Cuban, Mexican, If Yas, Give Year or Detes: 13. Was Decedent of Hispanic Original If Yas, specify Cuban, Mexican, If Yas, Give Year or Detes:	in? (Specify Yas or No- Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black						
15-002 72 hours natural;	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Bu	siness/Industry					
2121 d within jiene. r than on the Me	Elementary/Secondary (0-12) College (1-4or 5+)		D G	Schools					
other trees, tre	12th Bus Driver	's Neme (First, Middle,							
Maryland d 2 should be file th and Mental Hy 7 is marked other traumetic event	17. Father's Neme (First, Middle, Last) Alfred F. Wilson Ma	ry A. Gai		θ)					
arylan should be and Mental marked o imatic eve	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			State, Zip (MD) 20770					
Mar d 2 sho th and 7 is m traum	Laticia R. Wilson (Daughter) 6231 Spring								
ges 1 and 2 should be lied to 4 feet and 2 should be lied to 4 feet and Mental by or other traumatic event,	20a Method of Disposition (Name of			City or Town, State					
noi mt of mt of ror o	1 Burial 2 Cremation 3 Removal from State cematery, cremetory or other place)	1/8/00	Laure	1, MD					
Baltimore, It permit. Pages I and Department of Health Important if item 27 any Injury or other to other.	21. Signature of Service Lightage 22. Name and Address of Facility	,							
Ba Deem Deem Bany Is	SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850								
Physician /Medical Examiner	23a. Part1. Enter the duesse, or complications that caused the death. Do not enter the mode of dying, such as a shock, or hand to re. List only one-sause on each line. Immediate Cause (Final disease or condition resulting in death) ASSIVE CEREBRAL HAE Bue to (or as a consequence of): HYPER TENSON			Approximate interval Between Onset and Death					
is is	6.17			25 HOURS					
owecuted n and isl-transit Examiner	Sequentially list conditions, I Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
68760, ficate be executed physician and is the burial-transit edical Examir	triat initiated events			1					
0 ii 0	resulting in death) Last			1					
death certification of for use a	d			1					
- 0 9 6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use cor	ntribute to the cause of death?					
C T Va K	DIABETES MELLITUS	101	Yes 2 No 3 Probably 4 Unknown						
	DIACOLCS 110 CL105								
al Records, P.O. The law requires that the sate has been signed by the page 2 should be detach. Completed by Physical Ph	RENAL FAILURE	24a. Was a perfor	in autopsy med?	24b. Wera autopsy findings available prior to completion of cause of death?					
of Vital Rec Physician: The law this cardicate has ral director, page 2	HYPOTHY KOIDISM	1 D Y	es 200No	1 □ Yes 2 No					
Of Vital Physician: Tribis certificate ral director, partial direc	25. Was case referred to medical examiner?	of Death (Check only or	10)						
of Vita Physician: this cartific ral director,	1 ☐ Yes 25 No Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nur	rsing Homa 5□ Resid	ence 6 □Oth	er (Specify)					
ng Pl	27. Menner of Death 1 Description 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	28d. Describe h	ow injury occur	red					
Attending or death. ector: Attending by the fune fillication	2 Accident investigation M 1 Yes 2 N								
Division or Attending after death. Director: After d in by the fune	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet end Numb n, Stele)	er or Rural Route Number,					
Hospital 14 hours Funeral tely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end occurred at the time, date end one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deetly one)	d place, and due to the o h occurred at the time, o	ause(s) and ma late end place,	nner as stated. and due to the cause(s)					
To the comple	29b. Signature and littlefof certified and the state of t		29d. Date signe	d (Month, Day, Year)					
1	Addu (Nayeem. M. D 2129	4	01.	-04-00					
6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	•							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL NAYEEM M.D. 3450 FORT ME.	ADE ROAL	, LAIS	REL MD 25722					
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signature		1	11 1 NVIVI					

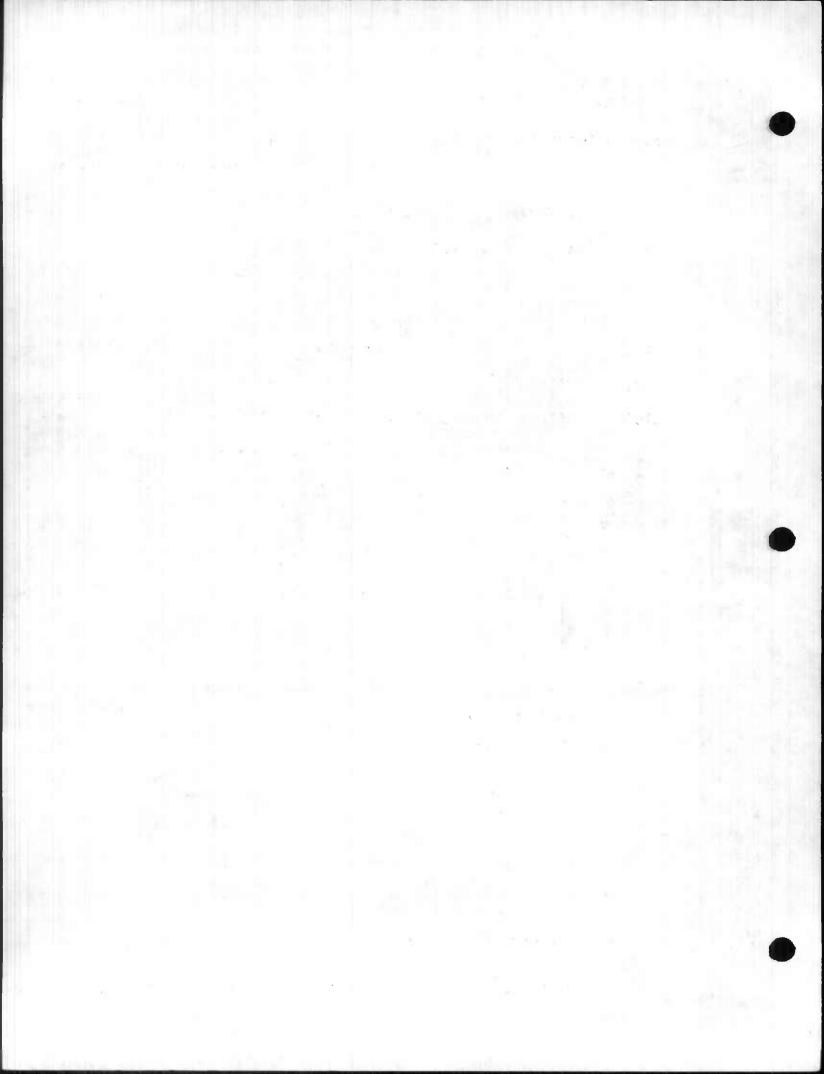
DHMH 16 Rev 6/95

State

Registrar

JAN 0 6 2000

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗎 🦳 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0656 JOHN M. WILLIAMS 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death MODITOOMERY GOVERN HOSPITAL DCWAY MONTEOMERY If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F 85 Yrs May 2, 1914 Wisconsin 391-10-6766 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Montgomery Maryland Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15101 Interlachen Drive, #207 20906 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No 1943 – If Yes, Give Year or Dates: 1973 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian. Biack, White, etc. 1 ☐ Never Married 2 N Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Administrator U.S. Government 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) William Alexander Williams Muzette Muriel LaGrave 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informant's Name/Relationship (Type, Print) John M. Williams, Jr. (son) 3519 Ludgate Rd., Chester, Virginia 23831 20b. Place of Disposition (Name of campletry, cremetory or other place) Uniformed Services University of the Health Science S22 Name and Address of Facility Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 33 Gist Avenue, Silver Spring, MD 20910 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00956 23a. Pall. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth CARCHOMA ESONATOUS Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequenca of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? CALCINOMY COLON 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en autopsy completion of cause of death? 2 X No 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) JYes 2 No 2 → R/Outpatient 3 DOA 28a. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

attending physicien end for use as the buriel-transit certificate be exec P.O. Box 68760. signed t Division of Vital Records, Completed page 2 s certificate has funeral director, After this deeth.

Physician

/Medical

Examiner

Director

Funeral

þ

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryler Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once.

Physician

/Medical Examiner

Examiner

Physician/Medical

ģ

Be

To

Certification:

edical

3 Sulcide

29e. Certifier

4 Homicide

(Cheak only

Baltimore, Maryland 21215-0020

with the Merylenc

Hospital or Attending Physician: efter deeth filled in by the within 24 hours To the Funeral I completely

10

0

29b. Signature and title of certifier nel.

6 Could not be determined

(OME)

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number 015 236

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and menner stelled.

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) JANUARY 3, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) (T

State Registrar

31. Date filed (Month, Day, Yeer)

JAN 07 2000

32. Registrar's Signature

books

1/7/2000 - centy tour by monty. County Vital Records

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** 2, 9:10 pm 2000 Wild January Lumir /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10225 Conover Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Feb 18, 1912 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 87 Yrs 082-09-5963 Director Usual Residence of Decedent the Maryland pernit. Pages 1 and 2 abould be filed within 72 hours after death with the Marylent Department of Health and Mentel Hyglena. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f ahow eny injury or other traumatic event, the Medical Exemple must be nomined at once. 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYAS 2 TANO Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10225 Conover Drive 20901 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ऒ Yes 2 □ No 1942— If Yes, Giva Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baitlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Worker 12 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) 8 Fred Wild 0 Josefa Darius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie A. Wild/ Daughter 10225 Conover Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan 4 20c. Location - City or Town, Stata 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 comas 23a. Part1. Enter the disease, or complications that clused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive Cardiomyopathy 5 years Examiner Due to (or as a consequence of): Examiner Hypertension 13 years physicien end the burlei-transit the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): . signed by the a P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mitral Regurgitation Division of Vital Records, P been sig 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Aortic Insufficiency page 2 s 1 Yes 2 No 1 ☐ Yes 2K No certificata tal or Attending Physician: Tra after death.

al Director: After this certificatied in by the funeral director, p. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

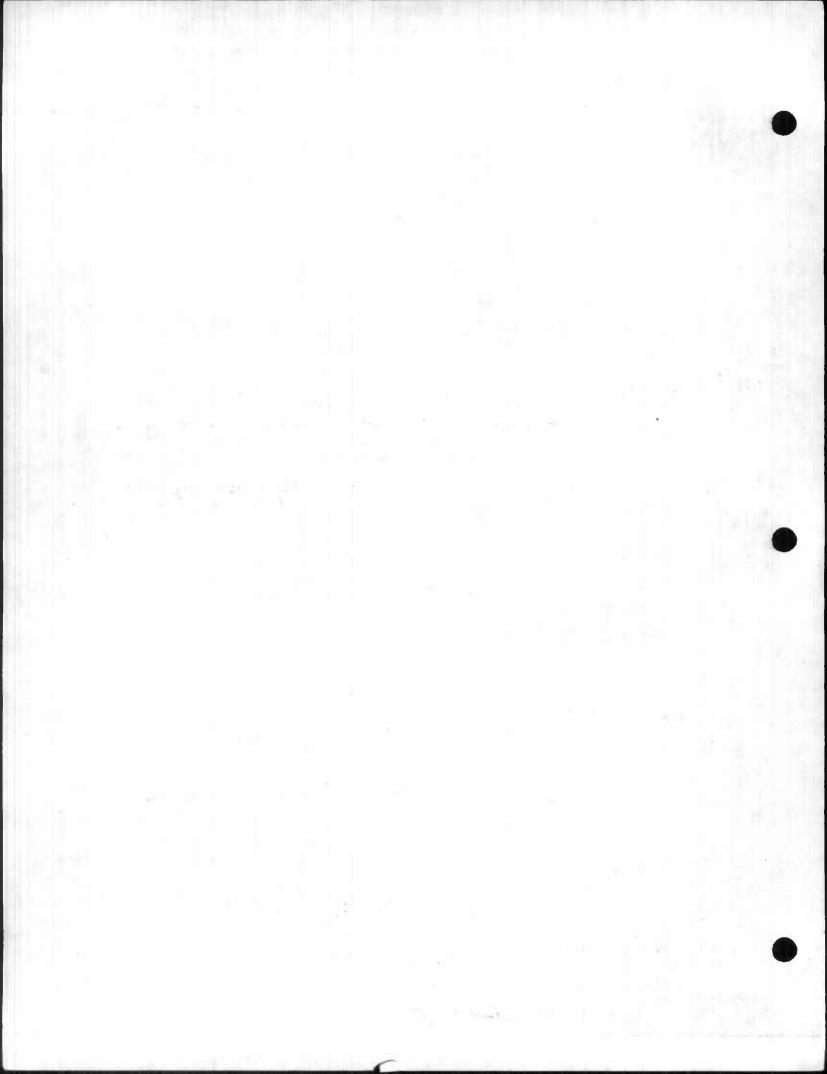
| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 10+1 Willes mg D31918 January 3, 2000 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 3305 North Leisure World Blvd., Silver Spring, MD Warren D. Ferris, M.D.

State Registrar

JAN 0 4 2000 DHMH 16 Rev 6/95

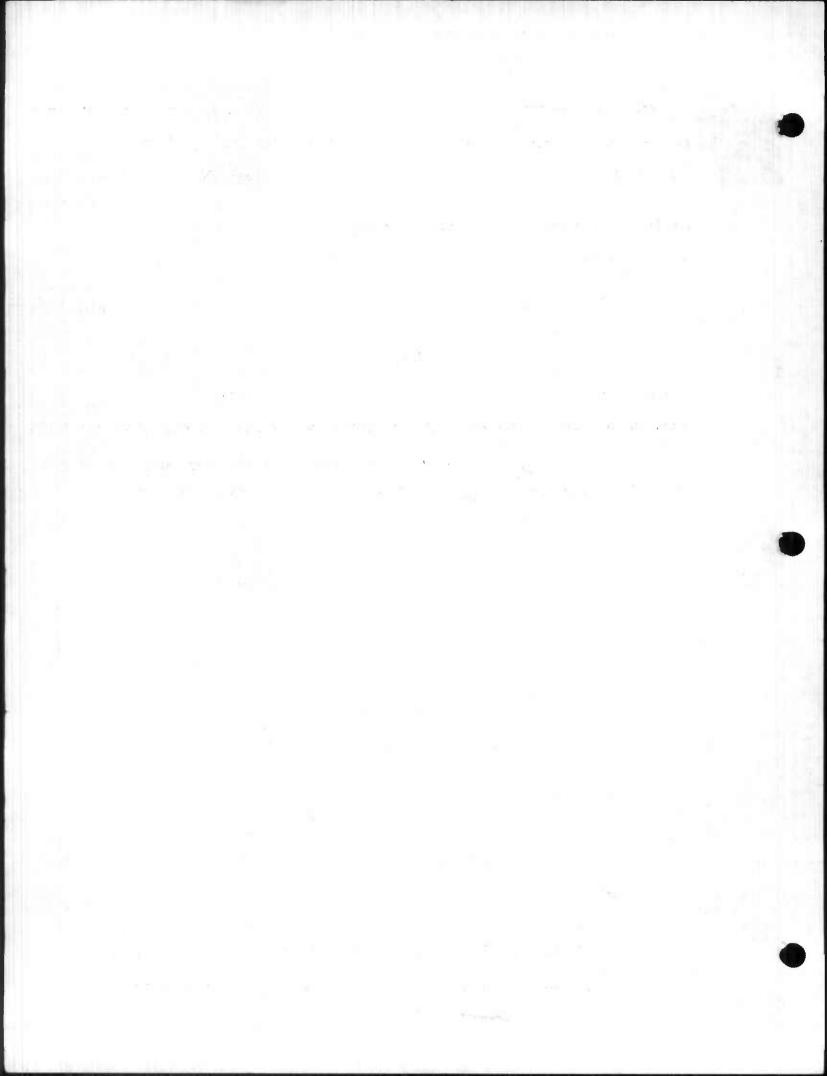
31. Date filed (Month, Day, Year)

32. Registrar's Signature oaks



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica				Reg. No.	111	0103.
ш	Physici	ian	Decedent's Name (First, Middla, Li	ist)					2. Data of De Month	Day	Year	3. Time of Death
	/Medi		Dorothy E. Wa	atson					Januar		000	5:30 a.
2	Examir		4a. Facility Nama (If not institution, gi	e street and number)				4b. City, Town, o	r Location of Deat	h 4c. County	of Death	
			Calvert County N	ursing Cent	er		P		rederick	Calv	ert	
	Funerai				in yrs. last bi	Month	ler 1 Year s Days	If Under 24 H		th v. Year)	9. Birthpie	ece (Stete or Forei
8	Director		377-03-0336	1□M 2只F	84	Yrs.	00,0	7.00.0	Sept.2	8,1915 W	Vashir	igton, D. C
	p ,		Usual Residence of Decedent		40- Oh. T-							
	anyla ehov	<u>.</u>	10a. Stata 10b. County		10c. City, Tov	n or Location					10	d. fnside City Limi
	M Par	cto	Maryland Montgo	mery	Silv	er Spri	ng					1 ☐ Yas 2 ☒ N
	F 9 F	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	Vhat Count	ry?
	23a		9305 Ocala Stree	t			20	0901		USA		
	de F	Funeral	11. Marital Status	12. Was Decedant E Armed Forcas?	Ever In U,S.	13. Was Dec	edant of H	lispanic Origin? en, Maxican, Pue	(Specify Yas or No		e - Amarica k. White, e	
20	n 72 hours after death with the Manyland "naturel", or Hems 23a or 28a-f show edical Expediter man be nythed at		1 Navar Married 2 Married	1 ☐ Yes 2 🔯 N	lo		2 🖾 No	Specify:	,	Specify		10.
8	ours	d by	3 ☑ Widowed 4 ☐ Divorcad	If Yes, Give Year or Datas:						эрвспу		hite
N.	I within 72 ho lene. • then "netur fre Medical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	188	. Decedent's Us (Give kind of a	vork done	eation during most of w	orking	16b. Kind of Bu	alness/Indi	ustry
2	within then then	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired	d)				
Maryland 21215-0020		CO	12			Homemak	er			Own F		
2	be file d othe event,	Be	17. Father's Name (First, Middle, Las.)				18. Mother's N	eme (First, Middle	, Meiden Sumam	Θ)	
3		2	Wilmer Griffin					Sue	Turner			
<u>a</u>			19a. Informant's Name/Reletionship	(Type, Print)	19	. Mailing Addre	ss (Street	end Number or i	Rural Route Numb	er, City or Town,	State, Zip	Code)
	C TO N F		J. Kenneth Watso	n (nephew) 10	55 Stoa	kley	Road P	rince Fr	ederick,	Mary]	and 2067
Baltimore,	of Healt of Healt I Item 2 r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Demouslfrom State	20b. Piaca o cemate	of Disposition (Nony, crematory of	lame of r other plac	ce)	Date	20c. Location -	City or Tov	m, State
Ĕ	Pages nent of I int: If he iry or o		4 □ Donation 5 □ Other (Speci		Rock C	reek Ce	meter	CV	01/07/20	OO Wachi	nator	n C
<u>=</u>	그 든 큰 등		21. Signature of Juneral Service Lice	nsee	noch c	22. Nama	and Addra	ss of Facility				La Da Ca
n	Depermine Deperm		V16.6.15	1Kann	en	Franci	s J.	Collins	Funeral	Home, I	nc.	
			23a. Part1. Enter tha disease, or con shock, or heart failura. List only	nniications that caused	the with Do	500 Un	ivers	sity Blv	d., W., Si	lver Spr	ing,	D 20901
η .			shock, or heart failura. List only	one cause on each lin	a.(not onto the m	ooo or ay ii	ig, odori do odrar	ac or raspiratory a	111004		Interval Between
•	Physician /Medical		Immediate Cause (Finel	^	c 0.0	0-1100	1	Pale	00 0011	4		
	Examiner		disease or condition resulting in death)	a	SPIK	HIION		INEU	CEIDS	77		5 DAY
		- a	30-00 7 3 8-00*.	0500	Due to (or as a	consequence o	f):	. 1	0 4 0 4	. 1		
	pet tisc	Examiner						KA	CE108	LNT	L	1 EARS
6	and al-tra	Xai	Sequentially list conditions, if any, leading to immediate	'	Due to (or as a	consequence o	f):				1	
3	ficate be axecuted physician and is the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c								
68760,	phys the	edicai	resulting in death) Last	ſ	Oue to (or as a	consequance of):				i	
				d								
ROX	death cert e ettendin ed for use	lan									1	
5	the de ny the ached	Physician/W	Part II. Other significant conditions	contributing to death bu	it not resulting	n tha underlying	cause giv	ren in Part I.	23b. Díd	tobacco use cor	ntribute to	the cause of deat
	thet the ded by		HUPER-	TENSION					10	Yes 20 No	3 Prob	ably 4 Unkno
S)	5 G	by										The control of the same of
0	requires been sign should be	Completed							24a. Was	en eutopsy ormed?	ava	re autopsy findings lable prior to
e c	2 s d	ple							-		of d	pletion of cause eath?
ב	0 - 0	Į,							10	Yes 2 No	10	Yes 2□ No
<u> </u>	ilcian: Thi certificate rector, pag	Be (25. Was case referred to medical					26. Place of D	eeth (Check only	one)		
or vital Record	Q w	To	examiner?	Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3 1	DOA Oth	er: Mursing	Home 5 ☐ Resi	dence 8 Oth	ar (Specify	
	ter th		27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of	28c. Injur Wor		T	how injury occurr		
Division	ath. r: At	atic	2 ☐ Accident investigation		1,44-7	М		Yes 2 □ No				
<u> </u>	Atte	Certification:	3 ☐ Sulcida 6 ☐ Could not be determined		ry - At home, fo	arm, street, facto	ory, office		28f. Location (City or To	Street end Numb	er or Rural	Route Number,
5	S at a	Ser		building, etc	. (Opecity)				Ony or 10	wii, Otaloy		
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier 1 Certifying Pi	nysician: To the best o	f my knowledg	e, deeth occurre	d at the tin	ne, dete and pla	ca, and due to the	cause(s) and ma	nner as ate	ited.
	HA Fu	edical	(Check only 2 Medical Example)	miner: On the besis of and manner sta	examination ar	nd/or investigation	on, in my o	pinion, death oc	curred at the time,	date and plece,	end due to	the cause(s)
	within 2 To the comple	Me	29b. Signatura and titia of ceptifier			2	9c. Licens	e number		29d. Data signed	d (Mgnth, E	ay, Year)
1			PHT	1 Mrs	1) N	20	74	0370		1/5	100	
	13		1000	, , ,		(Time Drivi)	UTC	10 10		. 15	100	
			30. Neme and address of parson who				d	T	al. Ma	10m2 000	70	
			Dr. Peter Wisnie 31. Date filed (Month, Dey, Year)		ospital rs Signature	Ka. Pr	TIICE	rreaeri	ck, mary	Tand 206	10	
	Sta	te ar	18N 0 7 20		. a orginature	1. /						



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 4, 2000 MARY HELEN YERKA 12:12AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 6. Date of Birth (Month, Day, Year) JULY 7, 1925 Birthplace (State or Foreign Country)
 ALABAMA **Funeral** Months Days Hours 1□M 2√2 F 205-14-4260 74 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berne 23a or 12811 MAPLE STREET 20904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. r than "natural", or lien the Medical Examiner. filed within 72 hours after Hygiene. ther then "natural", or the 1 Yes 2 No If Yes, Give A Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygers importants if them 27 is married other that any Injury or other traumette. HOME MAKER OWN HOME 9 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) 86 STANLEY SIMON HELEN KRASKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12811 MAPLE STREET SILVER SPRING, MD 20904 STEPHEN YERKA (SPOUSE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State PARKLAWN MEMORIAL PARK 1-7-2000 ROCKVILLE, MD 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility INES-RINALDI 11800 NEW HAMPSHIRE 24 Signature of Funeral Service Licens AVENUE SILVER SPRING, MD 20904 Part I. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as a consequence of) Examine CHRONIC OBSTRUCTIVE PULMONARY DISEASE physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, CORONARY ARTERY DISEASE Physician/Medical Due to (or as a consequence of): 98 980 ö 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? page 2 i has 1□ Yes 25 No certificate 1 TYes 2 TNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 2(No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral Hospital or Attending 1 ENaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047928 JANUARY 4, 2000 12

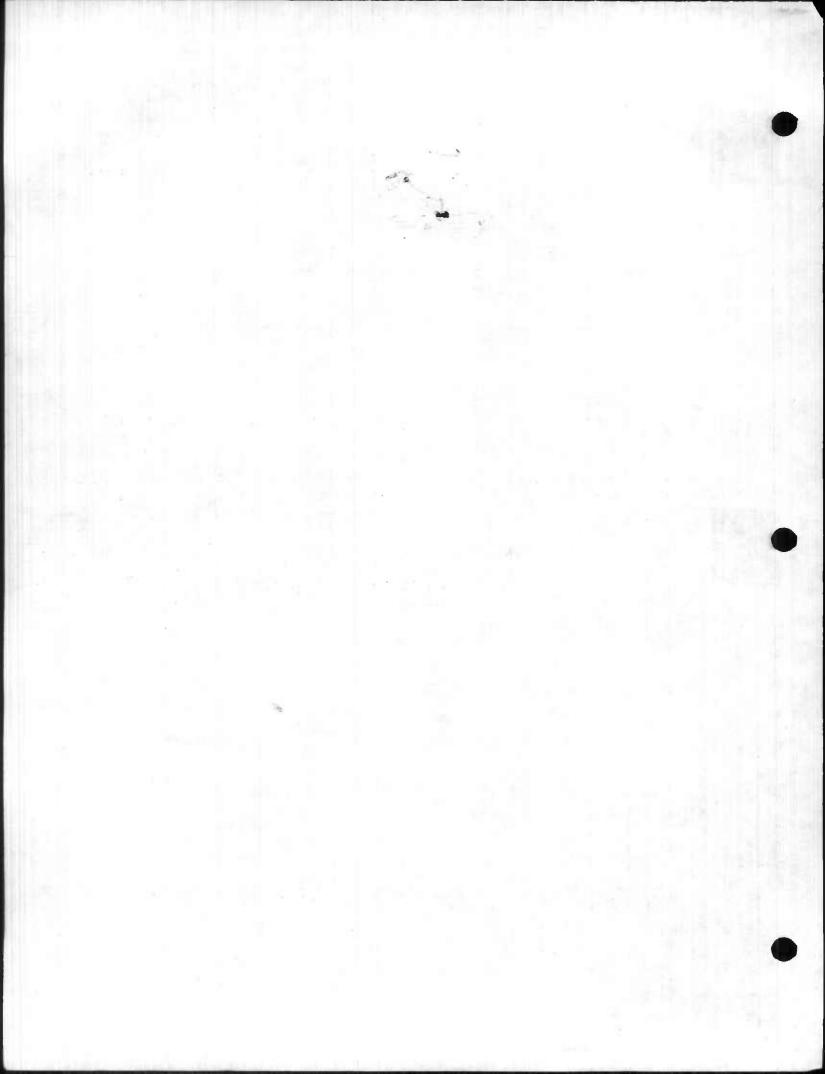
State Registrar

31. Date filed (Month, Day, Year) JAN 05 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILA BAHADORI M.D. 10301 GEORGIA AVENUE SILVER SPRING, MD 20902 32. Registrar's Signature

salls



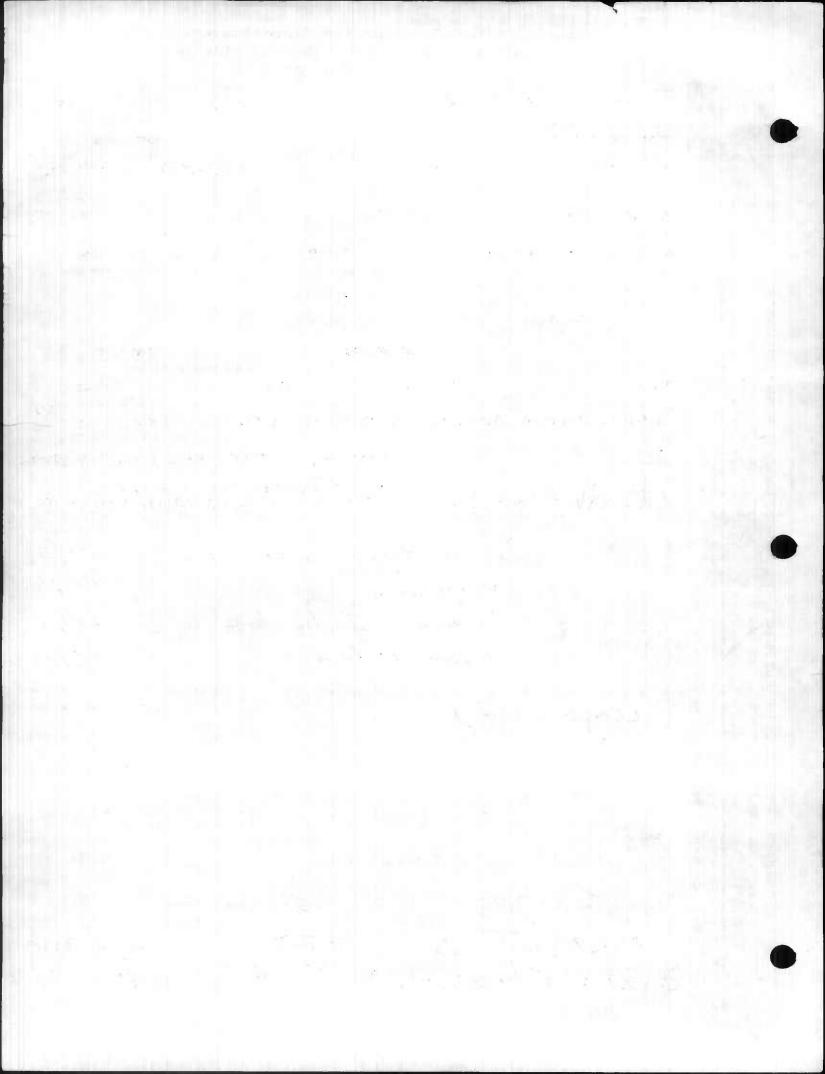
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Dey} 2000 **Physician** Catherine Mary Yauneridge 2, Jan. 6:37P. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 25, 1908 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 TYP Pennsylvania 188-22-4567 91 Yrs. **Director** Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner name be notified at Maryland Howard Clarksville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6538 Haviland Mill Road 21029 United States Funerai 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No. If Yes, Give Year or Dates: 14. Race - American Indien, Bieck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Merried 1 Yes XX No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) filed within Eiementery/Secondary (0-12) College (1-4or 5+) Hygiena. Homemaker own home is marked other 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumetic avent Jacob Harish Helen Padvorac 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20905 19a. Informant's Name/Relationship (Type, Print) Marian L. Alexander (daughter) 2100 Briggs Chaney Rd. Silver Spring, Maryland Baltimore, 20b. Piace of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremetion 3 Removel from State St. James Cemetery 1/7/2000 South Fork, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, P.A. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximete intervei Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only Physician Immediate Cause (Finel disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner ydvation ed by the attending physician and deteched for use as the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury schema MIDIAC that initiated events resulting in death) Last Due to (or as e consequence of); aclure Box tha death P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 Probably 4 Unknown na The that Records, þ The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en autopsy Deen cartificate has 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Wes case referred to medicel 26. Place of Deeth (Check only one) 1 | Yes 2 | 1 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Dimpatient 2 ER/Outpatient 3 DOA Aftar this eral Diractor: Aftar this 27. Manner of Death Dete of fnjury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? or Attending Patter death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steled.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completaly (Check only 29d. Dete signed (Month, Day, Year) 29b. Signatu 29c. License number 5 cause of death (item 23a) (Type, Print) 30. Name and address of pegal JAN 0 6 31. Date filed (Month 32. Registrar's Signature State 06 2000

Registra **DHMH 16 Rev 6/95**



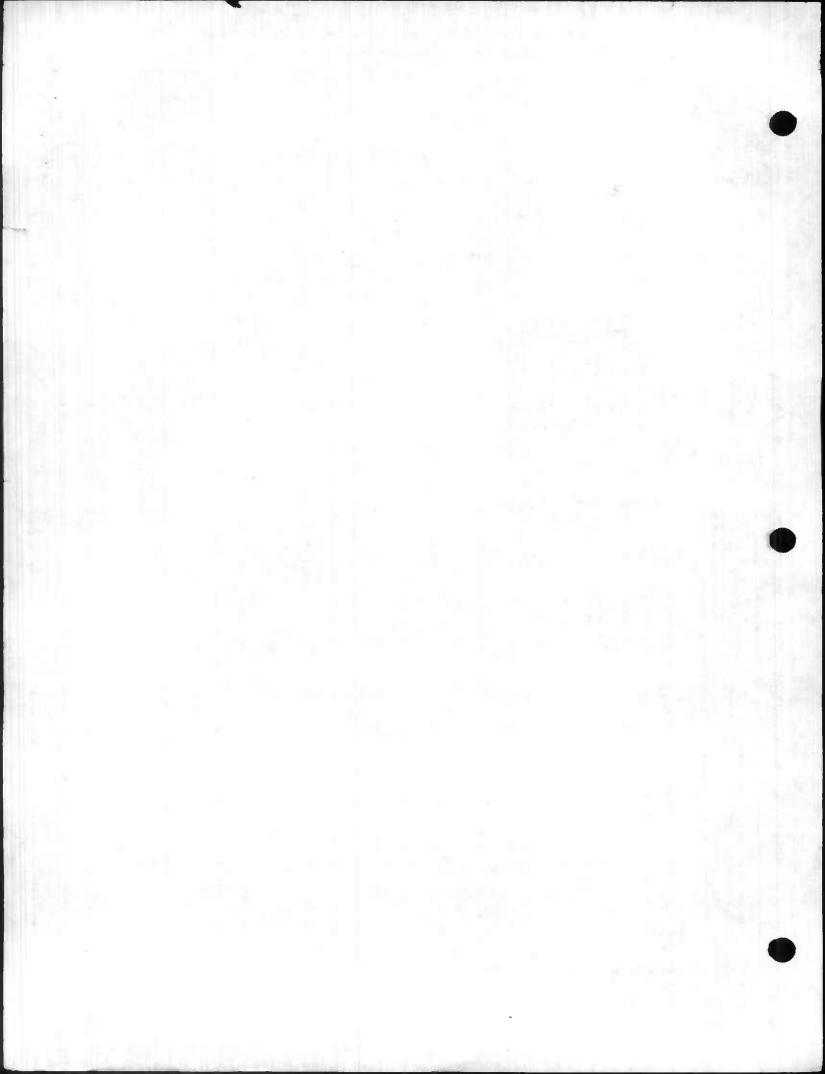
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Donnell Darrell Alston

State of Maryland / Department of Health and Mental Hygiene

nysician	1. Decedent's Name	(* ************************************	U.,					2. Date of D Month	eath Day	v Ye		me of Death
Medical	Donnell	D.	Alston					Janua				37 A.M.
xaminer	4a Facility Name (If	not institution, giv	e street and number)				4b. City, Town,	or Location of Dea	ith 4c.	County of D		
11.5			le Street	. 1		T #41 + 41	Baltim			N/A		
neral ector	5. Social Security Nu 218-08-2	2729	Sex 7. Ag	14	ast birthday) Yrs.	Months D		#rs. 8. Date of 8 (Month, E 06 - 2	irth Day, Year) 1-85	9.	Birthplace (S Country)	MD
be notified at Director	1	10b. County			, Town or Lo		11.7					ide City Limits
be notified Director	MD	NA		Ва	ltim	_						Xies 2 140
	10e. Street and Num		ne Stree	t			1213			USA		47
Examiner must by Funeral	3 ☐ Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pr INO Specify:	(Specify Yes or Nuerto Rican, etc.)	lo-		American fndi White, etc. Blac	
r, the Medical	(Specif	15. Decedent's Ed by only highest gradery (0-12)	ducation ade completed) College (1-4or	5+)	(Give	edent's Usual C e kind of work of DO NOT use r udent	done during most of	working		ind of Busine		
, S	8th Gr		NA		DC	udelle						
Be e			land				Darl	Name (First, Middl ene		lsto:	n	
To To	-				40h Maili	ing Address (C	Street and Number of		har Cibra	or Tourn Sta	te Zin Code)	2121
Page 1	19a. Informent's Ner Darlene		ton				Caroline					
di p	20a. Method of Dispo	osition			ace of Disp	osition (Name	of	Date			y or Town, Sta	
à	Burial 2	Cremation 3 5 Other (Specif	Removal from State	Gr	enerery, cre	omatory or other	Cemetery	01-15-	2000	Bal	timor	e,MD
i d	21. Signature of Fun		···				Address of Facility	1				
yas Sas	1/enen	a	benty			WM.C.N	March FH	1101 E	. No	_		
17 1)			of dying, such as car					al Between and Death
niner j	Immediate Cause (F disease or condition resulting in death)		a _Shotgi	un Woi		o Neck						
lcal Examiner	disease or condition resulting in death) Sequentially list condition to many leeding to improve the condition of the conditi	ditions, nediate tying njury	shotg	Due to (or	und_to	O Neck equence of):						
edical Examiner	disease or condition resulting in death) Sequentially list con- if any, leeding to im- cause. Enter Underl Cause (Disease or in that initiated events resulting in death) Le	ditions, nediate tying njury	aShotgu b c	Due to (or	und to	O Neck equence of):						
for use as the burlat-transit used as the burlat-transit used as the burlat-transit used for	disease or condition resulting in death) Sequentially list con- if any, leeding to im- cause. Enter Underl Cause (Disease or in that initiated events resulting in death) Le	ditions, mediate hying njury	b c	Due to (or	es a conse as a conse as a conse	o Neck equence of): quence of):				uss contrib	Onset	and Death
for use as the burlatransit and standard and	disease or condition resulting in death) Sequentially list con- if any, leeding to im- cause. Enter Underl Cause (Disease or in that initiated events resulting in death) Le	ditions, mediate hying njury	b c	Due to (or	es a conse as a conse as a conse	o Neck equence of): quence of):		23b. Di	d tobacco	v	Onsel	and Death
be detached for use as the burlat-transit by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condition from the condition of	ditions, mediate hying njury	b c	Due to (or	es a conse as a conse as a conse	o Neck equence of): quence of):		23b. Di 1[d tobacco	× No 3[buts to the c	euss of death 4 Unknow
mpleted by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condition from the condition of	ditions, mediate hying njury	b c	Due to (or	es a conse as a conse as a conse	o Neck equence of): quence of):		23b. Di 1[24a. Wa per	d tobacco	No 30	buts to the c	euss of death 4 □ Unknow opsy findings prior to n of cause
page 2 should be detached for use as the butlat-transit Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condition if any, leading to improve the cause. Enter Underland Cause (Disease or in that initiated events resulting in death) Language. Part II. Other signific	ditions, mediate lying njury ast	b c d	Due to (or	es a conse as a conse as a conse	o Neck equence of): quence of):	se given in Part I.	23b. Di 1[24a. Wa per	d tobacco	No 30	Donsel Doubt to the completic of death?	euss of death 4 Unknow opsy findings prior to n of cause
I director, page 2 should be desched for use as the bunk-transit. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list condification of the condition	ditions, mediate lying njury ast cant conditions of the cant conditi	b c d contributing to death b	Due to (or Due to (or Due to (or	as a consecutive of the consecut	ont 3 DOA	se given in Part I. 26. Place of Other: 4 \(\text{ Nursin} \)	23b. Di 1[24a. We per	d tobacco Yes 2 se en autor formed? XYes 2 y one) sidence	psy 2 No 3[buts to the completic of death?	euss of death 4 Unknow opsy findings prior to n of cause
Il director, page 2 should be detached for use as the burishransman. To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condification of any, leading to immigrate the cause. Enter Underflower that initiated events resulting in death) Leading in death) Leading in death (a) Part II. Other signification of the cay aminer? 1. Was case referred against 2. Was case re	ditions, mediate lying ast cant conditions c	b	Due to (or Due to (or Due to (or Due to (or	as a consect as a consec	o Neck equence of): quence of): quence of): underlying cause ent 3 □ DOA of 28c.	se given in Part I. 26. Place of	23b. Di 1[24a. Wa pel 1[Death (Check only ng Home 5 □ Re 28d. Describ Subjection	d tobacco Yes 2 is en autor formed? XYes 2 y one) sidence e how inju Ct Wa	psy 2 No 3[No 3[No 3] No 3[No 3]	buts to the completic of death?	euss of death 4 □ Unknow opey findings prior to on of cause 2□ No SCENE
I director, page 2 should be desched for use as the bunk-transit. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list condification and cause. Enter Underland Cause (Disease or in that initiated events resulting in death) Lease of the condition of the	ditions, mediate lying ast cant conditions of the conditions of the cant conditions of the	b	Due to (or	es a consect as a	ont 3 DOA of 28c.	26. Place of Other: 4 Nursin N	23b. Di 1[24a. Wa per 1[1] Death (Check only ng Home 5	d tobacco Yes 2 Is en autor formed? XYes 2 Yone) sidence e how inju Ct Wa (Street ar own, State	psy 2 No 3[No 3[No 3] No 3[No 3[No 3] No 3[No 3[No 3[No 3] No 3[No	buts to the completic of death? 1 DXYas (Specify) at t.	euss of death 4 □ Unknow opey findings prior to on of cause 2□ No SCENE
I director, page 2 should be desched for use as the bunk-transit. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list condition and the condition of any, leeding to immoduse. Enter Underflow that initiated events resulting in death) Leading in death and the condition of the condition	ditions, mediate tying njury ast cant conditions of the conditions of the cant conditions o	b	Due to (or All pury and pu	es a consect as a	equence of): quence of): quen	26. Place of Other: 4 Nursir Injury et Work? 1 Yes 2 0 No office	23b. Di 1 C 24a. Wa pel 1 C Death (Check only) 1 G Bel 28d. Describ Subject 28f. Location City or 7 Baltir lace, and due to the	d tobacco Yes 2 Ayes 2 Yone) sidence e how inju Ct Wa (Street ar own, State MOYE, e ceuse(s	psy 2 No 3[No 3[No 3] No 3[No 3[No 3] No 3[No 3[No 3[No 3] No 3[No	Donsel Donsel	euss of death 4 Unknow opsy findings prior to on of cause 2 No SCENE
I director, page 2 should be desched for use as the bunk-transit. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list condification of any, leading to immoduse. Enter Underline Cause (Disease or in that initiated events resulting in death) Later of the condition of th	ditions, mediate lying injury ast cant conditions of the conditions of the cant cant can	b	Due to (or All pury and pu	es a consect as a	on Neck equence of): quence of	26. Place of Other: 4 Nursir Injury et Work? 1 Yes 2 0 No office	23b. Di 1 C 24a. Wa pel 1 C Death (Check only) 1 G Bel 28d. Describ Subject 28f. Location City or 7 Baltir lace, and due to the	d tobacco Yes 2 Is en autor formed? XYes 2 Yone) sidence e how inju Ct Wa (Street ar fown, State ONE, e ceuse(s) e, date and	psy 2 No 3[No	Donsel Donsel	euss of death 4 Unknow opey findings prior to on of cause 2 No Scene e Number, nVale
pletely filled in by the funeral director, page 2 should be detached for use as the burishtransit and edical Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list condification of any, leading to improve that initiated events resulting in death) Leading to the cause. Enter Underthat initiated events resulting in death) Leading in death in the capacity of the capacity in the capacity in death in the capacity in the capacity in the capacity in death in the capacity in	ditions, mediate lying injury ast cant conditions of the conditions of the cant cant can	b	Due to (or All pury and pu	es a consect as a	on Neck equence of): quence of	26. Place of Other: 4 Nursin N	23b. Di 1 C 24a. Wa pel 1 C Death (Check only ng Home 5	d tobacco Yes 2 Is en autor formed? Yes 2 Yone) sidence e how inju Ct Wa (Street ar own, State more, e ceuse(s, e, date and	psy 2 No 3[No 3[No 3] No 2 No 3[No 3[No 3] No 3[No 3[No 3] No 3[No 3[No 3[No 3] No 3[No	buts to the completic of death? 1 Divas (Specify) at t. or Bural Boute E. Lal Land er as stated.	Buss of death 4 Unknown opsy findings prior to on of cause 2 No SCENE ause(s)

to the



00-0256-510 jhm **JOHN** DIANTON

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	\mathbf{H}	1	
eg. No.	U		1

041

3 Probably 4 Unknown

24b. Were autopsy findings aveilable prior to completion of cause of death?

Yes 2 No

DITEMIT	JIN				00.11110	W.C 01	5000		rieg. rec.		
9	Physician /Medical	Decedent's Neme (First, Mide John Gr		nton				2. Dete of D Month JANUA	Dey	Yeer 2000	3. Time of Deeth 23:08 PM
3	Examiner	4a Facility Name (If not institution	on, give street end number,)			4b. City, Town, or l	ocation of Dee		inty of Deeth	
		1202 NORTH MII	TON AVENUE				BALTIMOR	E	1	IA	1.0
	Funeral Director	5. Social Security Number 213-66-9057	4DM ODE	ge (In yrs. la:	st birthday) If Ur Yrs. Mont	hs Deys		8. Dete of B (Month, E 12-20	irth Day, Year) 0-54	9. Birthi Cou	place (Stete or Foreigntry) MD
D		Usual Residence of Decedent									
Maryler	notified at rector	MD 10b. Count	I'A		Town or Location						10d. Inside City Limits X□XYes 2 □ No
th with the		10e. Street and Number 1359 Pentwo	od Road			Zip Code 2123	9		10g. Citizen	of What Coul	ntry?
5-0020 72 hours after death with the Maryland	it, or hams 23.	11. Meritel Stetus 11 Never Merried 2 Me 3 Widowed 4 Divorce	If Yes Give	? [No		ecedent of specify Cu	Hispenic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Rece - Americ Bleck, White, ecify: Bla	etc.
15-00	ygiene. er than "nature ft, the Montel Completed	15. Decede (Specify only high	nt's Education est grade completed)		16a. Decedent's U	Isuel Occu	upetion e during most of wor ed)	king		of Business/in	dustry
2121 d within	or than	Elementary/Secondery (0-12)	College (1-4or	5+)	Sanit				Depar Balti	artment of timore City	
E 8	marked other matic event, the	17. Father's Name (First, Middle John D.	. Last) Blanton	18. Mother's Nan Hattie							
	alth and 27 la m r traum	19e. Informant's Neme/Reletion Hattie B.	ship (Type, Print) Blanton				et end Number or Au ood Road				
TOL	5 2 2	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (C8/	b. Place of Disposition (Name of cametery, cremetory or other place) Arbutus Mem.Pk.Cem. O1-20-2000 Arbutus, MD						
Balt Permit.	Department Important: I any Injury o	21. Signatife of Funeral Service	Daus				ress of Fecility B				and 21202 enue
A IT	ysician Medical aminer	23a. Part1. Enter the disease, shock, or heart feilure. In the shock, or heart feilure in the shock, or heart feilure. In the shock, or heart feilure in the shock, or heart feilure. In the shock, or heart feilure in the shock, or heart feilure in the shock feilure	a.	tob	Do not enter the	rel	ying, such es cardiac	Les V	arrest,		Approximete Intervel Between Onset and Deeth
760, e be executed	sician end e burlal-transit cal Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or a	as e consequence	of):					

The law requires that the death certifica

use as th yd bengis

Division of Vital Records, P.O. Box

To the Hospital or Attending Physician:

s after deeth.

within 24 hours a To the Funeral I

completely

Physician/Medi þ Medical Certification: To Be Completed 25. Wes case referred to medical exeminer? 27. Manner of Death

resulting in death) Last Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t.

fX Yes 2 No

1 Neturat

2 Accident

3 Suicide

Homicide

29a. Certifier

1 Inpatient 2 ER/Outpatient

00 Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

NEE

3 DOA 28c. Injury et Work? 1 Yes

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 NOther (Specify)

24e. Wes en eutopsy performed?

1 Yes 30 No

(Street end Number or Rural Route Number, own, Stete) 28f. Location (Stre City or Town,

23b. Did tobacco use contribute to the cause of death?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Si

5 Pending investigation

6 Could not be determined

29c. License number OCME

29d. Dete signed (Month, Day, Year) JANUARY 16, 2000

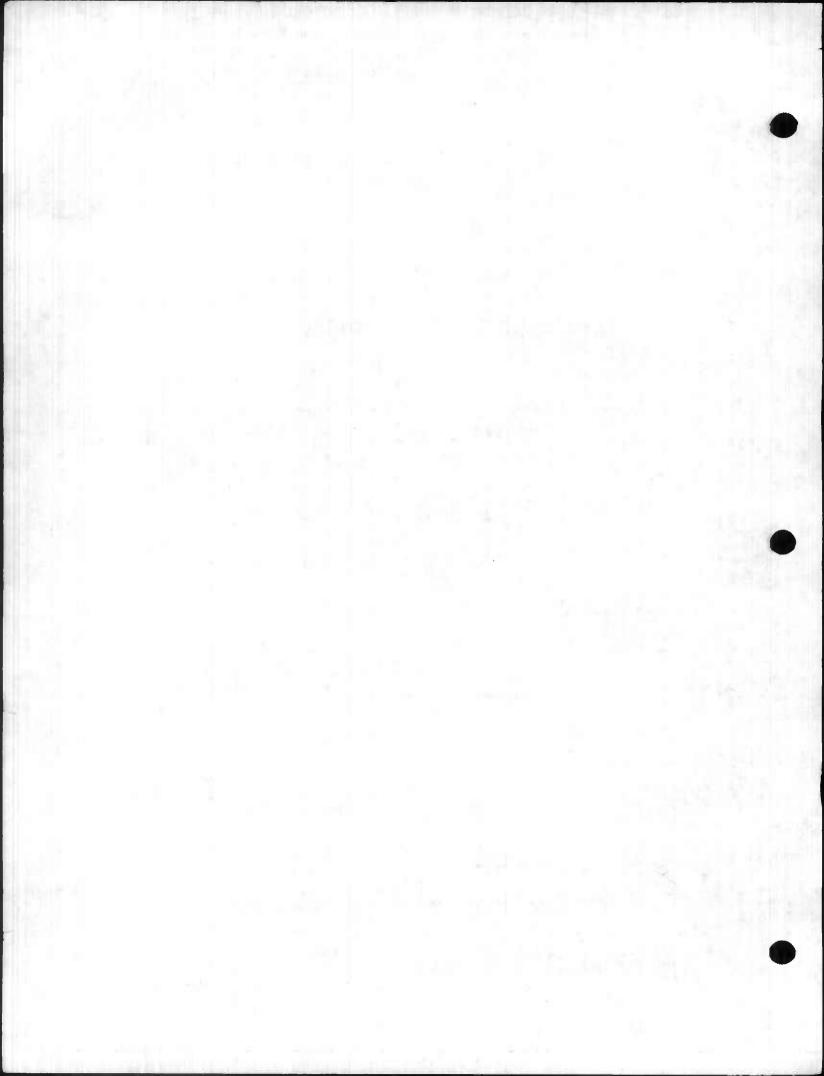
completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

State Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death	U	46
Certificate of Death Reg. No.		

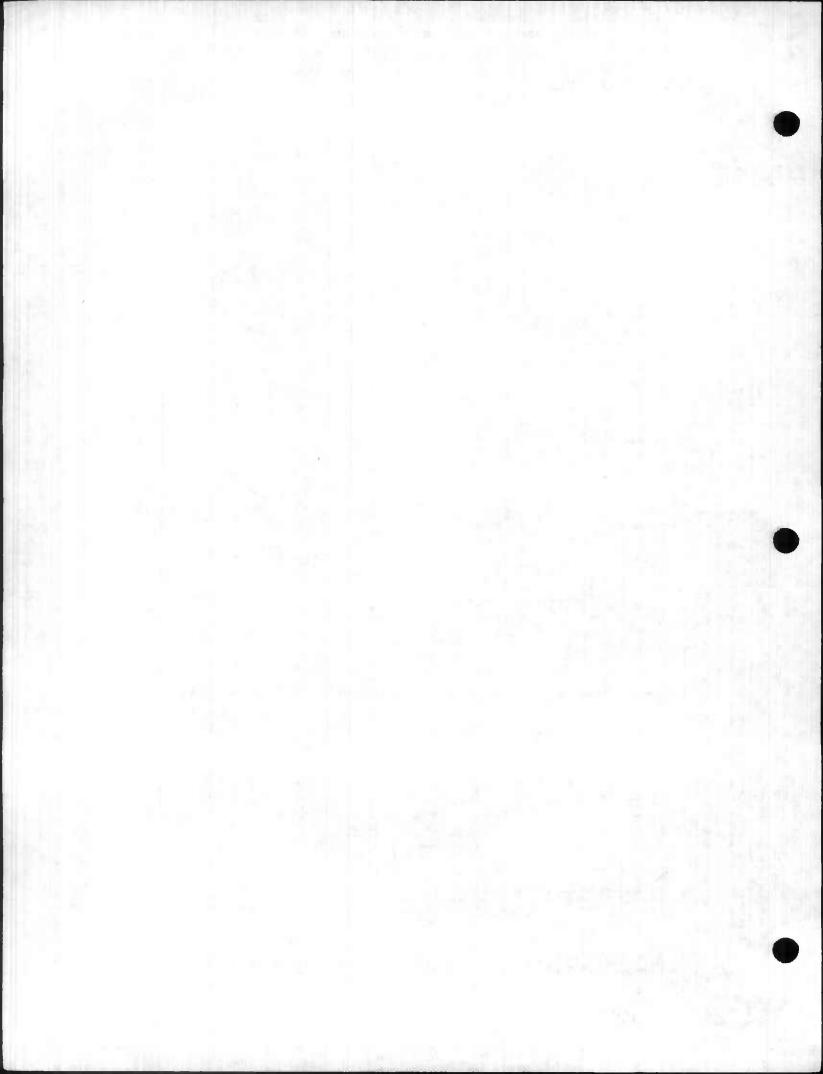
				Certificate of	Death	R	eg. No.		
	1. Decedent's Name (First, Middle, L.	nst)				2. Date of Deat Month	h	Vees	3. Time of Death
hysician Medical	DARRYL	BUI	LER			JANUAR	y ¹ 15, 2	000	1455 PM
aminer	4a Facility Name (If not institution, gi 1600 BLOCK OF MO	ve street end number) UNTMOR COU	RT		4b. City, Town, or BALTIM	Location of Death	4c. County	of Death	
ral tor	212-86-9162	.m., .m.	ge (In yrs. lest birt	hday) If Under 1 Yea Months Days				9. Birthpla Country MD	ice (State or Foreig y)
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				100	d. Inside City Limit
Funeral Director	MD NA		BALTI						1 Yes 2 □ N
Il Director	10e. Street and Number 5104 LAUREL AN	/E.		10f. Zip Code 2121	5	1	Og. Citizen of V	Vhat Countr	y?
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Decedent Armed Forces? 1 1 Yes 2 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul		Specify Yes or No- into Rican, etc.)		e - American k, White, et	c.
Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ede completed) College (1-4or: NA	5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin ar Detail	ipetion a during most of wo ed)	orking	W. Gre		
	17. Father's Name (First, Middle, Las			ar Detail	18 Mother's Na	ame (First, Middle, M	Jeiden Sumem	(a)	
o Be	JOHN BUTLER	,				GREGOR		9	
	19a. Informant's Name/Relationship CLEO WARREN —			Mailing Address (Street 104 LAURE		Rurel Route Number BALTO.		State, Zip C	_
	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Speci		cemeter	Disposition (Name of y, cremetory or other pl		Date 1-21-00	20c. Location -		m, State
and a	21. Signature of Funeral Service Lice		-		ress of Facility uneral	Home, W	est, I	nc.	In 17
edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b	Due to (or as a c	consequence of):					
lan/M		d							
Physic	Part It. Other significant conditions	contributing to death b	out not resulting in	the underlying cause g	iven in Part I.	23b. Did to		3 Prob	the cause of deat
Completed by						24e. Was e perform	n autopsy ned?	avai	re eutopsy findings lable prior to apletion of cause eath?
Com						Der	s 2 No	De	Yes 2□ No
Be	25. Was case referred to medical examiner?				26. Plece of De	eeth (Check only on	e)		
To Be	1∭Xes 2□ No	Hospital: 1 Inpatie	ent 2 ER/Ou	tpatient 3 DOA	ther: 4 Nursing	Home 5 ☐ Reside	nce expoth	er (Specity)	SCENE
Certification:	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not lead to the lead of the le	28e. Plece of In	100 /4	M 28c. Inj	Yes 2 No	28d. Describe ho	reet and Nymb	840	Route Number,
edical C			f examination and	death occurred at the for investigation, in my					
Medical Certificat	29b. Signatury and title of certified	rleur)	29c. Licer	.C.M.E.	2	9d. Date signed		
State	30. Name and address of person who 31. Date filed (Month, Dey, Year)	completed cause of the CFF AND 32. Registr				re, Maryla			2000

State Registrar

JAN 1 9 2000

32. Registrer's Signeture

Sporks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEMS #10a,10b PER FH G779 1/19/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** a: a5pm January Arthur Baumgartner 10,3000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death-4c. County of Deeth Examiner Square Hospital Center | Hunder 1 Year Sosedale If Under 24 Hrs. 8. De Franklin Baltimore 8. Dete of Birth (Month Day, NOV 28, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MT **Funeral** Months Devs Hours 1916 1 M 2 □ F MD Director 217-07-4964 83 Usuel Residence of Decedent the Meryland 10a. SteteMD 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at N/A 1004 George Avenue 17 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be 1004 George Avenue 21221 USA Berrs 23a Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. 11. Marital Status Bleck, White, atc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Arthur Baumgarther Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ☑ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 truck driver state highway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental John Baumgartner Anna Leonard 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: if hem 27 is any injury or other trac once. Thomas Baumgartner 402 Wilgis Road Fallston, MD 21047 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director sec 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart feiture. List only one causa on each line. Approximete Interval Betwe Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) neumonia Examiner Due to (or es a consequance of): Examine Infarction dhours ardia physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in death) Last Dua to (or es a consequence of) Box 68760 Physician/Medicai Due to (or es e consequence of) 980 Part ff. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed' The law page 2 s 1 ☐ Yes 1 □ Yes 2 □ No of Vital Physician: Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: After 5 Pending investigation Division Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital 29a. Certifier Certifying Physician: To the best of my knowledga, death occurred at the time, date end plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai (Check only one) To the To the To the 29b. Signeture end title of cartille 29c. License number 29d. Date signed (Month, Day, Year))98 January 10, 2000

State Registrar 30. Name and address of pe

Dr Stephen

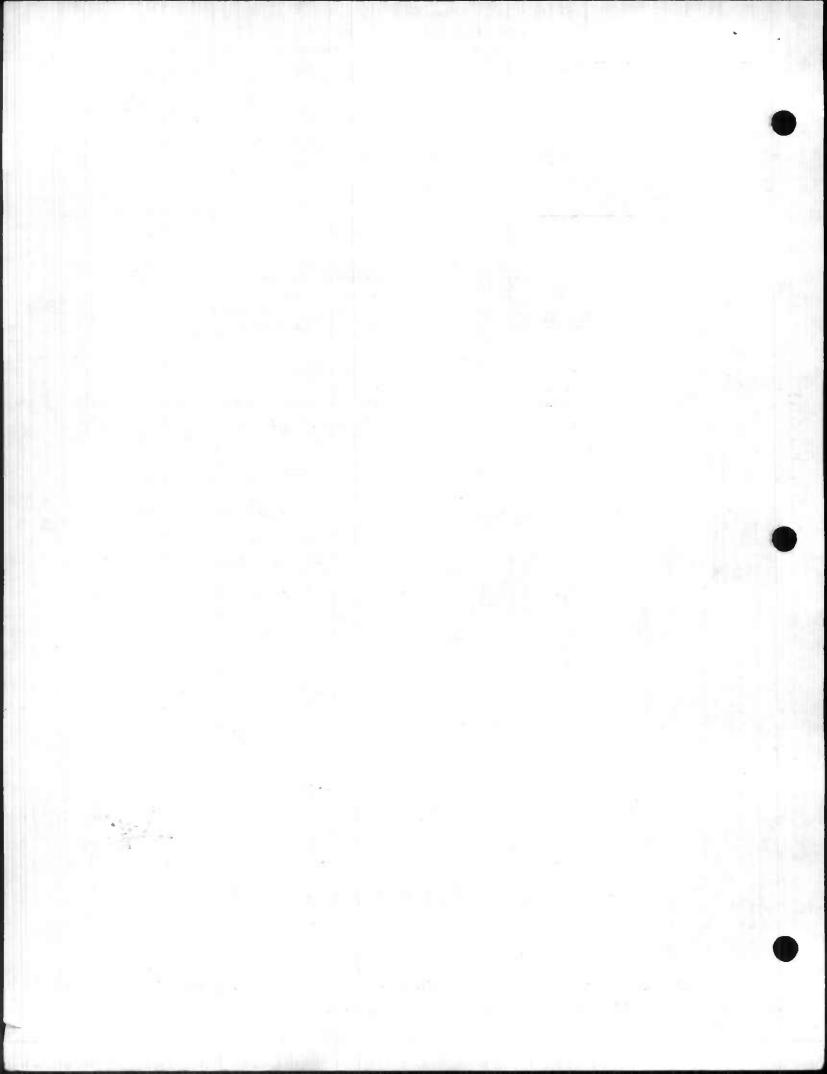
ling

DHMH 16 Bay 6/95

dr 9000 Franklin Square Drive Baltimore Maryland 21237

use of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month BARRETT, SR CRAIG L. 8:15 pm Laci 0) 4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) MD Baltimore If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Deta of Birth (Month, Day, Year) Months Days Hours 48 Yrs. 216-58-2697 17,1951 Sept. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 S. Brunswick Street 21223 United States Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Earl Leroy Barrett Ethel Regina Everly 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mary Donna Marie Barrett - wife 909 S. Brunswick Street, Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1/17/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause of each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in death) arrhosis 71.61S End-Stage wes umknowo Due to (or as a consequence of): dise ase Acute Rena Due to (or es a consequence of):

Physician /Medical Examiner

physicien end s the burlai-transit

for use as

signed by the a d be deteched f

certificate has b

this funeral

After

after death.
Director: Aft

To the Hosp within 24 hox To the Fune completely fi

6

filled in 24 hours Hospital

Medical

State

Registrar

29a. Certifie

The lew requires that the death certificate be axecuted

Box 68760.

Records, P.O.

of Vital

Division or Attending **Physician**

/Medical

Examiner

Directo

by

Completed

10a. State

Funeral

Director

ahow

r than "natural", or Name 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or here eny injury or other traumatic event, the Medical Exemples bace.

Baitimore, Maryland 21215-0020

death with the Maryland

Examine Physician/Medical þ Completed 8 Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Wara autopsy findings available prior to completion of causa

1□ Yas

of death?			
1 🗆 Yas	20	No	

25. Was casa referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. trijury at Work? 28d. Describe how injury occurred

5 Pending investigation 1 Natural
2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and titla of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

Mobashery, m.D

3396

1/13/2600

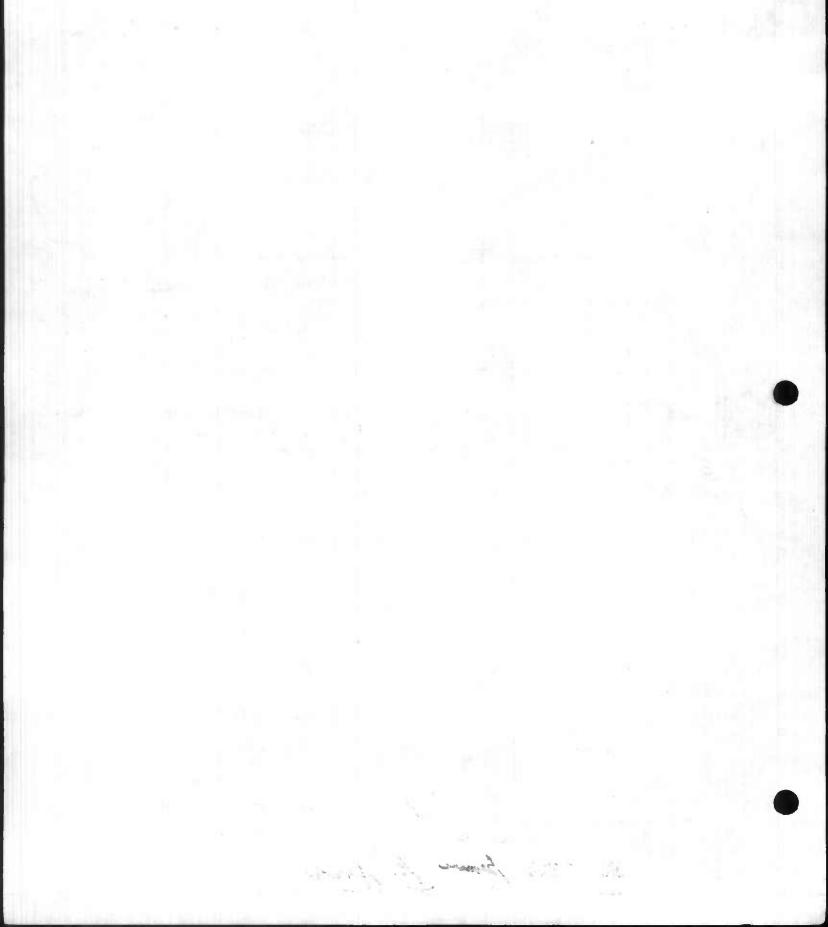
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

medicine Dept. 0

- University

31. Date filed (Month, Day, Year)

32. Registrer's Signatura JAN 1 9 2009



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2000 5:30 p.M. John W. Bloch Hanuary 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center osedale Battimore If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 180 M 2□ F Months Hours 175-18-0644 83 June 27,1916 Michigan Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8201 Featherhill Road 21128 United States Apt. 104 12. Was Decedent Ever in U,S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Foreman Steel Industry 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First, Middle, Maiden Surname) John Dzieciolkiewiz Jozefa Staskiewisz 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1430 Perryman Road Aberdeen, Maryland 21001 Alfred Bloch (Son) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Rosedale, Maryland Gardens of Faith Cem. 1/21/2000 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. ario Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final stage Chronic obstructive Pul monary disease disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200No 3 Probably 4 Unknown Myocardial Infarction 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? No 1 Tyes 2 No

Physician /Medical Examiner

Physician

Examiner

10a. State

Funeral

Director

#how

must be notified at

"natural", or

Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien, Important: If Nem 27 is marked other that any Injury or other traument.

Maryland 21215-0020

altimore,

Box 68760.

P.O.

Records,

Division of Vitai

Directo

þ

88

/Medical

physician and the burial-transit The law requires that the death certificate be executed been signed to the should be detected as the state of the certificata al or Attending Physician: T a after death. Il Director: After this certificat ed in by the funeral director, p

Examiner Physician/Medical à Be Completed Certification: To Medical

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

State Registrar

25. Was case referred to medical Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a, Certifier 29b. Signature and little of certifier

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

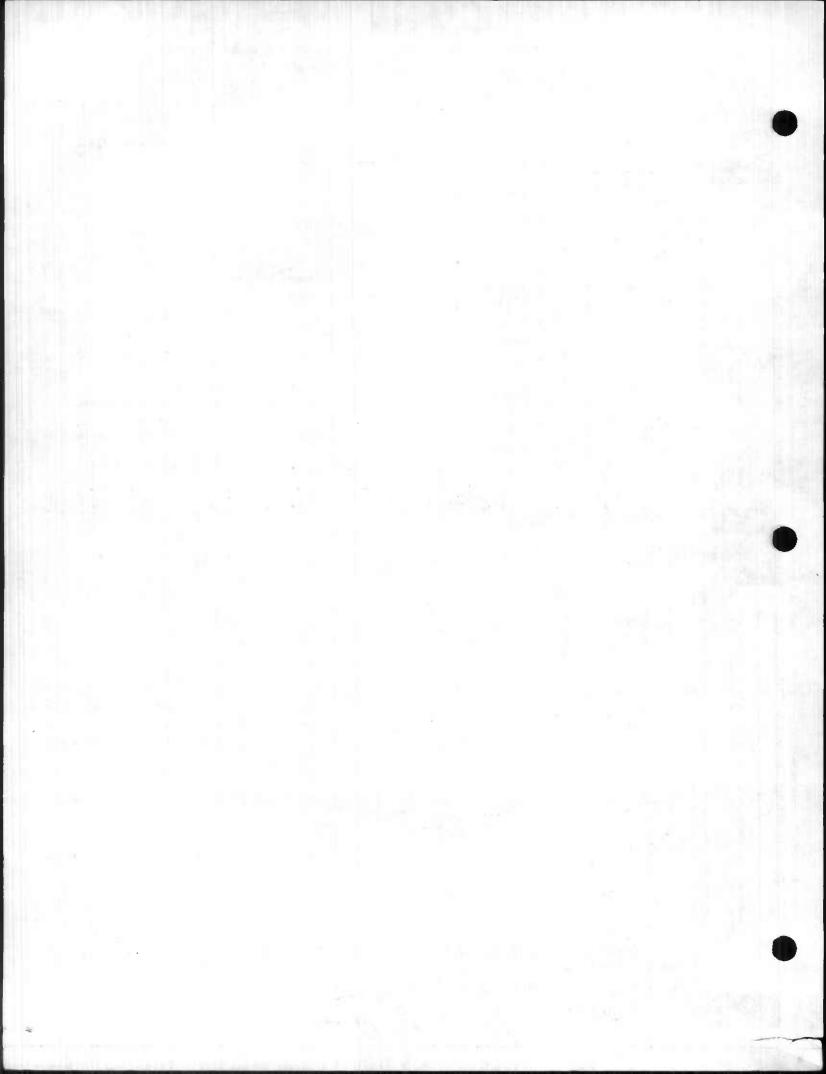
completed cause of death (Item 23a) (Type, Print)

9000 Franklin 31. Date filed (Month, Day, Year)

JAN 19 2001

32. Registrac's Signeture

Square Drive Baltimore, Maryland 21237



Piease Type or Print in Biack Indeiible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Edward Borman 4b. City, Town, or Location of Death 4c. County of Death 0337 2000 4e Facility Nama (If not institution, give street end number) Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 13M 2□ F 215-16-5819 79 June 18,1920 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dundalk Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 834 Mildred Avenue 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. ty Yes 2 No If Yes, Give 1 Never Married 2 Merried 1 ☐ Yes 2 € No Specify: Specify: White 3℃Widowed 4 Divorced Yeer or Deles:1944-45 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Years Truck Driver Pharmacy Delivery 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Rudolph Borman Freida (Unknown) 19e. Informent's Neme/Ralationship (Type, Print) (Daughter) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Beverly E. Borcato 834 Mildred Avenue Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete toBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest V.A.Cem. 1/20/2000 Owings Mills, MD 21 Signature of Juneral Sarvice Licenses 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Ma. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one ceuse on each line. Dundalk, Maryland 21222 Approximata interval Between Onset and Death Immediate Causa (Finel Stroke month diseese or condition resulting in death) Due to (or es a consequence of). Sequentielly list conditions, if any, leeding to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or es a consequance of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical axeminer? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

Pue the deeth certificate be exec the th signed to be det

Box 68760,

P.O.

Records.

Division of Vital

Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Wedical Exercises must be notified at

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked other any injury or other traumatic avant pance.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

ò

Completed

Be

Examiner Physician/Medical þ Completed director, 89 Certification: To this After death. To the Hospital or Attendition 24 hours after death.

To the Funeral Director: A completely filled in by the fu

5×1

edicai

State

Registrar

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Mennar of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted.

RES-000

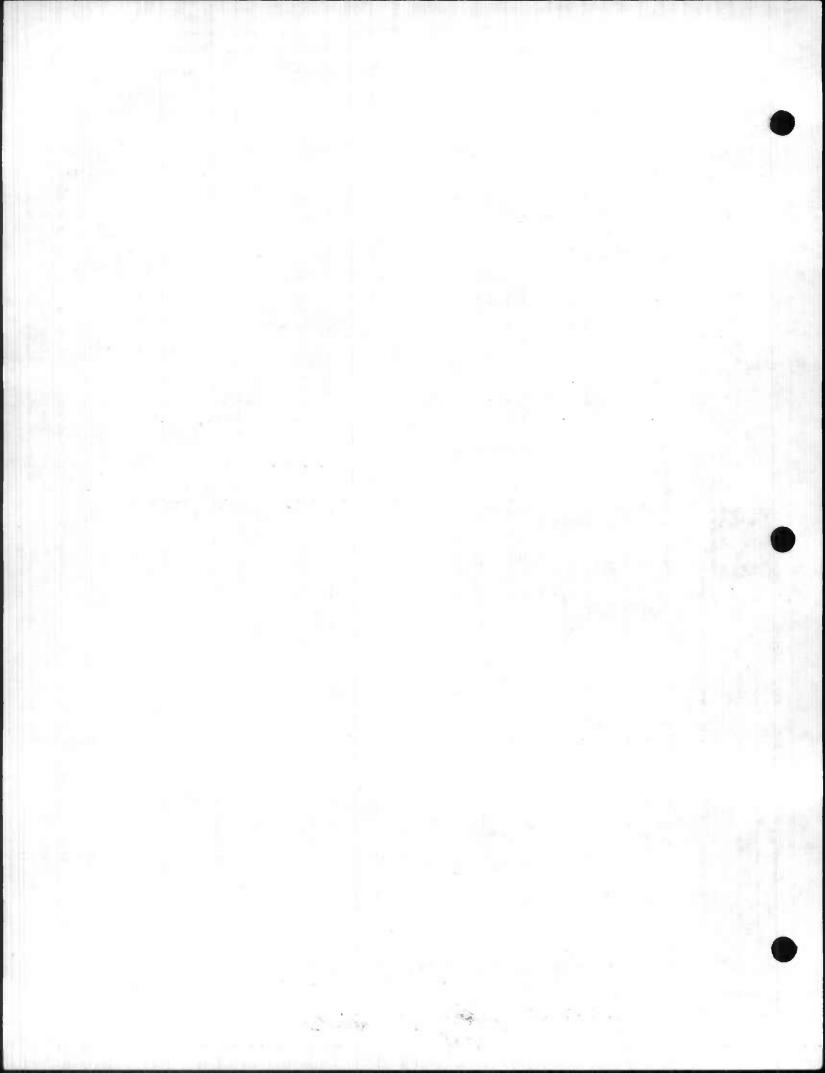
29c. License number

29d. Data signed (Month, Day, Year) January

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

Lyanchen 600 North Wolfe Freet, Baltimore, Margland 21287 Connie MD 32. Registrar's Signeture

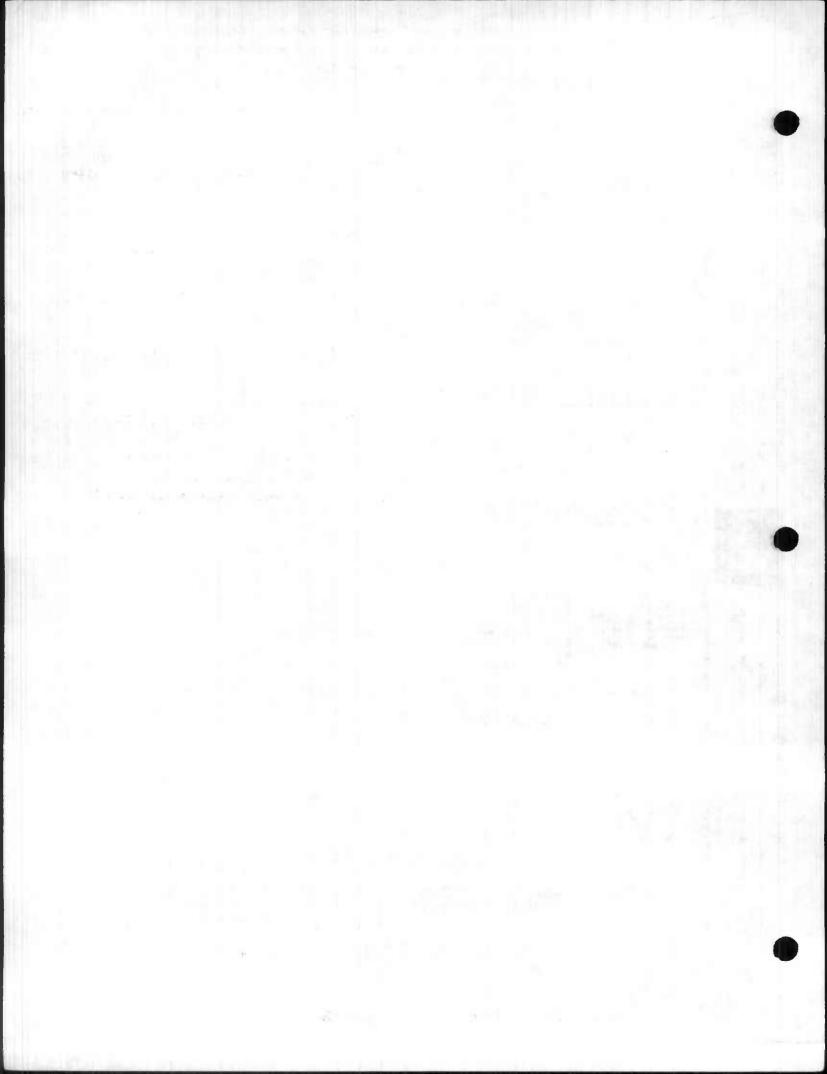
31. Date tiled (Month, Dey, Year) JAN 19 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	S	tate of Marylan		artment of I		and Mental H	lygiene ()	0 01	047
Physician	1. Decedent'e Name (First, Middle, Last)	Dishaud Tau	de Des			2. Data of Month		Year	Time of Death
/Medical		Richard Lou	is Bur	losk1	4 O' T	Janua			7:50 PM
Examiner	4a Facility Name (If not institution, give street	er and number)			Par i 1	wn, or Location of D		y or Death N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday	If Under 1 Year			Birth		(Stata or Foreign
Director	164 22 4541 ^{1⊠ M}	2□ F 71	Yrs.	Months Days	Hours	Min. (Month, NOV •	Day, Year) 24, 1928		ylvania
D >	Usual Residence of Decedent 10a. Stata 10b. County	100 6%	y, Town or L	· ·				101	lander Otto Linear
within 72 hours after death with the Maryland ens. than "natural", or herms 23e or 28e-f show he sented Exempler must be notified a empleted by Funeral Director	Maryland Anne Arund		en Bu						Inside City Limits
S S S	10e. Street and Number	iei Gi	en bui	10f. Zip Code			10g. Citizen of		
N N N N N N N N N N N N N N N N N N N	513 Mayo Road			210	61		U.S	-	
or hems 23s or 28s-1 show inflor mast be notified at 7 Funeral Director	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of	Hispanic Orig	in? (Specify Yes or Puerto Rican, atc.)	No- 14. Rec	ce - Amarican li ck, Whita, atc.	ndian,
A DE	1 Never Married 2 Merried	1∭X Yes 2 □ No If Yas, Give		1 ☐ Yas 2 🖾 No		, r agrico r nouri, aco.,	Specif		-0
feted by	3 ☐ Widowed 4 ☐ Divorced	Year or Datas: W . W .	II	1					
Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working	160. Kind of B	usiness/Indust	У
ф	Elementary/Secondary (0-12)	College (1-4or 5+)	Dire	ector - H	Bureau		Veterin	ary Med	dical
90	17. Father's Name (First, Middle, Last)		7		18. Mothe	r's Name (First, Mid	dle, Maiden Sumer	ma)	
ToB	Loui	is A. Bunosk	ci			Mary Sh	arkus		
	19a. Informant'e Name/Relationship (Type,					r or Rural Routa Nu			
	Sylvia Bunoski / W. 20a. Method of Disposition			Mayo Roa			en Burnie, Maryland 210 Deta 20c. Location - City or Town,		
É	1 ☐Burial 2 ☐ Cremation 3 ☐ Remo	oval from Stata		osition (Nama of matory or other pla	-	1/20/0			Maryland
_	4 Donation 5 Other (Specify) 21. Separation of Funeral Servicin Licensee	Ma		e Vetera					
g	4. 10			ghway Ba	Funeral				
the budal-transft gical Examiner	Immediate Cause (Final disease or condition resulting in death) a	S (Dua to (a	EPS ras a conse	quence of):					E WEEK
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a conse	quence of):					- 67
Medical	Cause (Disease or injury that initiated events resulting in death) Last	Dua to (o	ras a consec	quence of):					
lated by Physician/Med	- 0								
Physician/Med	Part II. Other significant conditions contribu				iven in Part I.		☐ Yee 2 No		v 4 □ Unknown
by Pi	DILATED CA	TRDIOM	YOP	ATHY			Yee 20XNo	3 LIOOHDI	, - Gonknown
Completed t							as an autopsy erformed?	evailat	outopsy findings ble prior to etion of cause th?
mo						1	□Yas 2 No	1 D Ye	
B. C	25. Was case referred to medical				26. Place	of Death (Check or			
To	examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2	ER/Outpatie	N 3LI DOA		rsing Home 5 P	esidence 8 🗆 Ott	her (Specify)	
ations	1 Natural 5 Pending 2 Accident investigation	8a. Data of Injury (Month, Day Year)	28b. Tima o Injury	Wo	unyat ork?]Yes 2 ☐ i		be how injury occur	rred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At he building, atc. (Specify		reel, factory, office		281. Location	n (Street and Numi Town, Stete)	ber or Rural Ro	outa Number,
edical	29a. Certifier (Check only one) 12 Certifying Physicia 2 Medical Examiner:	n: To the best of my known on the basis of axaminal and mannar steted.	wledge, deet tion and/or in	h occurred et the t vastigetion, in my	ime, date and opinion, deat	d place, end due to h occurred at the tir	the cause(s) and m na, date and place,	anner as state , end dua to the	d. cause(s)
completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signature and title of certifier			29c. Licen	se number		29d. Data aigne	ed (Month, Day	Year)
	45	MO		RES	-00	6	Januar	4 16.	2000
	30. Name and address of people who comple	eted cause of death (Item	23a) (Type,	Print)			mo -	217 16	-
State	31. Data filed (Month, Day, Year)	32. Registrar's Signa	tura d	dere	MUE,	Balt,	1110 0	11213	
State	JAN 1 9 2000	Double of	19	Sour	1,				

DHMH 16 Rev 6/95

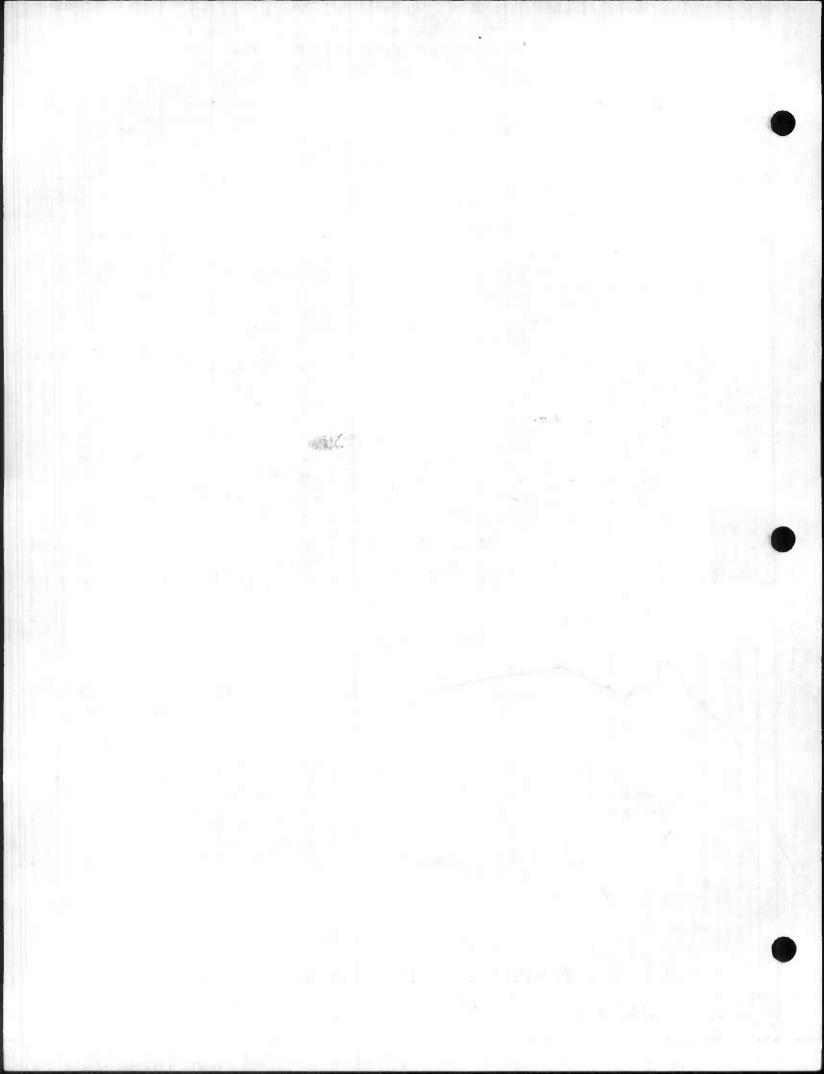


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int \) Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** JANUARY 2000 12:00 PM Ann Elizabeth Baker /Medical 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Center Towson If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 XF Director 6 Jan. 11, 2000 Maryland Usual Rasidence of Decedent with the Maryland 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland Baltimore Directo N/A 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 4335 Hamilton Avenue 21206 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? Black, Whita, atc. Novar Married 2 Married 1 ☐ Yas 2 🗓 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify. White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Not Self Supporting Dependent 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Baker Neal Kathleen Maher 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) . Item 27 Mr. Neal Baker / Father 4335 Hamilton Avenue Baltimore, MD 21206 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Data 1 D Burial 2 Cramation 3 Ramoval from Stata = 5 St. John's Long Green 1/17/2000 Hydes, Maryland 4 Donation 5 Dother (Specify) 22. Nama and Addrass of Facility Leonard J. Ruck, 21. Signature of Fundant Service Licensee Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the liseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart infure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** EXTREME PREMATURITY 4 HOURS /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): 6 MINS. Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician the buria Physician/Medical Due to (or as a consequence of) USB 85 signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ۵ by Records, The law requires Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 ☐ Yas 2 No 1 ☐ Yas 20 No certificate of Vital Physician: Be 25. Was casa retarred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Panding invastigation 1 Natural 2 Accidant or Attending after death. 1 ☐ Yas 2 ☐ No 6 Could not be datermined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, sfreef, factory, office building, atc. (Specify) filled in by 4 ☐ Homlcide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mennar as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medicai completely (Check only one) within 2 ş 29c. License number 29d. Dafa signed (Month, Day, Year) 29b. Signatura and titla of certifian D 0027352 nera 30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print)
MARILYN H. BENNETT, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204

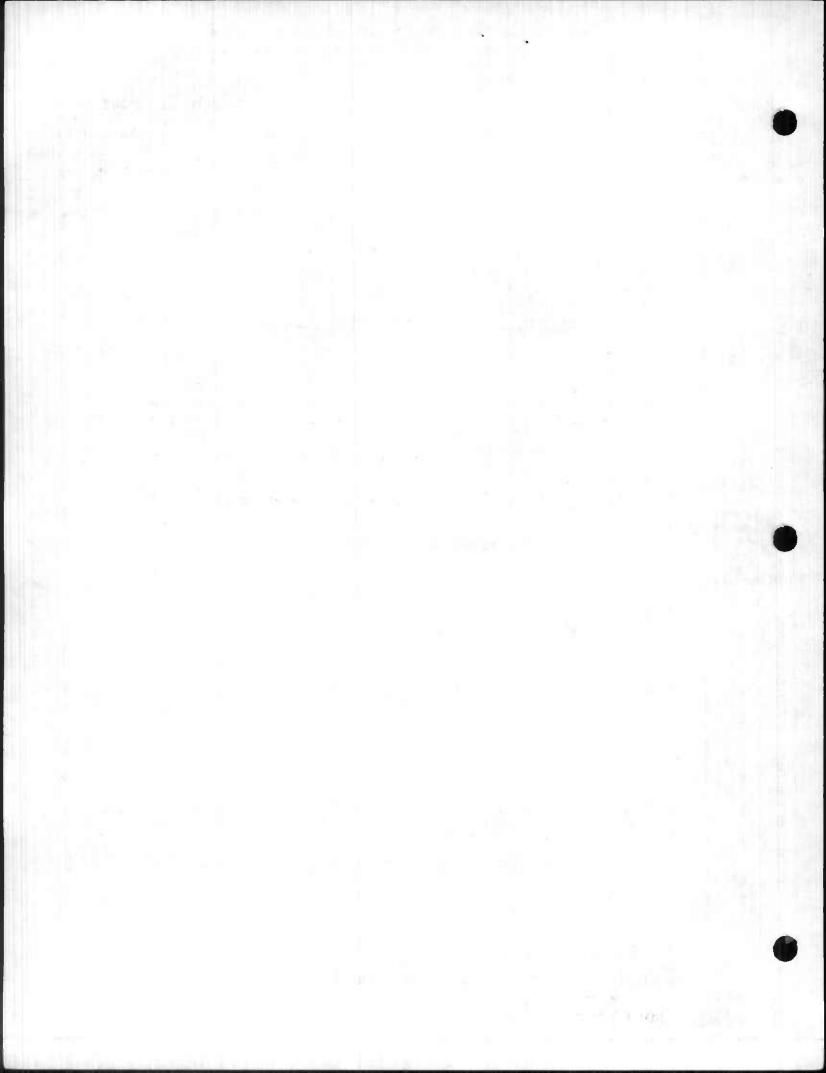
44

DHMH 16 Ray 6/95

State Registrar 31. Data filed (Month, Day, Year) JAN 19 2000 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY **Physician** 2000 10:29 AM 11, Julia Terese Baker /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1□M 2X F Months Director 13 January 11, 2000 Maryland **Usual Residence of Decedent** MAHER-BAKER, B. 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 United States Funeral 4335_Hamilton Avenue Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'e Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Dependent Not Self Supporting 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 8 Pages 1 and 2 should be nent of Health and Mental Kathleen Maher Neal Baker 19a. Informant'e Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a vit: if item 27 is Mr. Neal Baker / Father 4335 Hamilton Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 □ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 1/17/2000 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. John's Long Green 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Service Licenti 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the distribute, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** EXTREME PREMATURITY 2 HOURS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner 13 MINS The law requires that the death certificate be executed the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pue Due to (or as e consequença of): physician Physician/Medicai Due to (or as a consequence of): 080 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2N No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Tyes 2 No To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0027352 - Emas LOW 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MARILYN H. BENNETT, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204 31. Date filed (Month Day, Year) 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 050 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY 2000 12:10 PM 11. Grace Kathleen Baker 4a Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore Hours Min. 8. Dete of Birth (Month, Dey, Year) 3 55 Jan. 11, 2000 5 Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 200 F Months Yrs. Maryland Usual Residence of Decedent 10a Stete 10b County 10c City Town or Location 10d. fnside City Limits X Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 21206 4335 Hamilton Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Not Self Supporting 0 Dependent 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Kathleen Maher Neal Baker 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21206 4335 Hamilton Avenue Mr. Neal Baker / Father 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17/2000 Hydes, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) John's Long Green 22. Name end Address of Fecility Leonard J. Ruck, 21. Signature of Funetal Service License Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EXTREME PREMATURITY 3 HOURS Immediate Cause (Fine) disease or condition resulting in death) Due to (or as a consequence of): 55 MINS. Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 Tes 25. Was case referred to medical axeminer? 26. Piace of Deeth (Check only one) 1 ☐ Yes 2X No Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel

The law requires that the deeth certificate be exec physician 100 USB be det Division of Vital Records, page 2 certificate funeral director. this Attending ne Hospital or Attending in 24 hours after death. he Funeral Director: Aft pletely filled in by the fur

Examine Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

28a-f

ð

238

b

Hygiene.

Pages 1 and 2 should be till ment of Health and Mental H ant: If tem 27 is marked olb lury or other traumatic even

Physician

/Medical

Examiner

The Marylan

MAHER-BAKER,

Maryland 21215-0020

Baltimore,

Physician/Medical by Completed

Medical

2 Accident 3 Suicide 4 Homicide

29e, Certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

5 ☐ Pending investigetion

6 Could not be determined

28a. Dete of fnjury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. fnjury at Work? 1 TYes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D 0027352 29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARILYN H. BENNETT, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204

State Registrar

completely To the To the To the

31. Dete filed (Month, Day, Year)

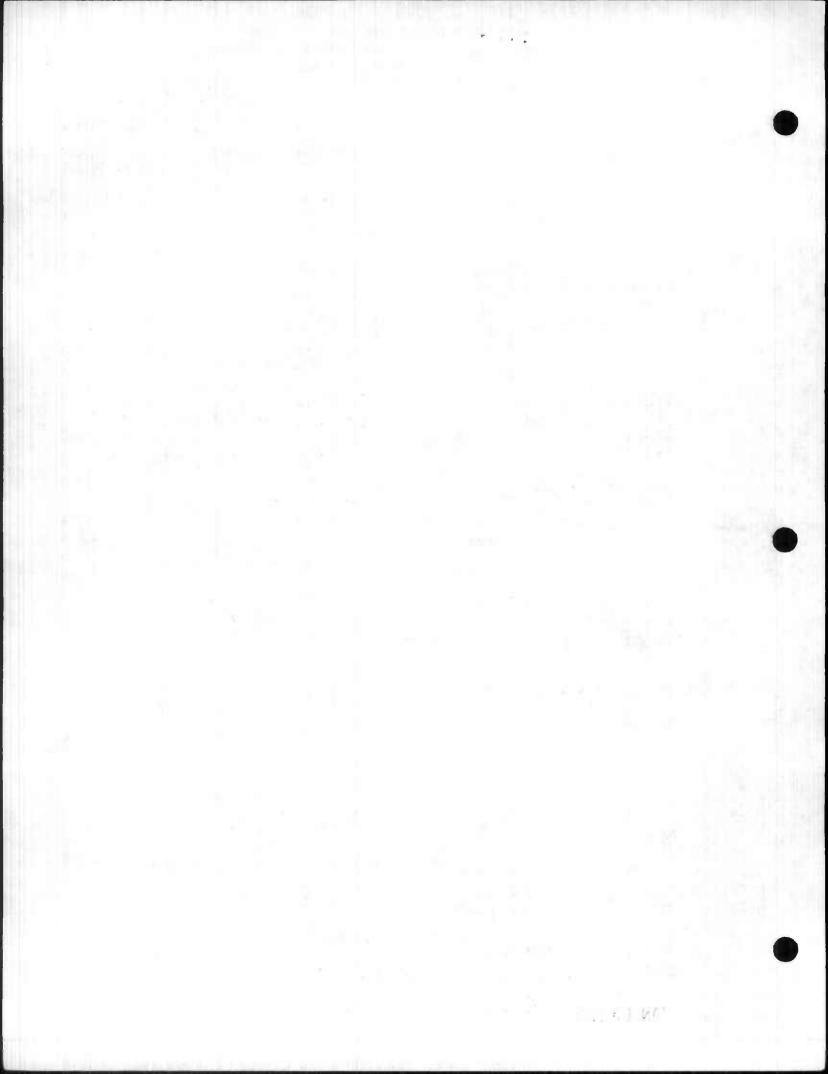
29b. Signature and title of certifier

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

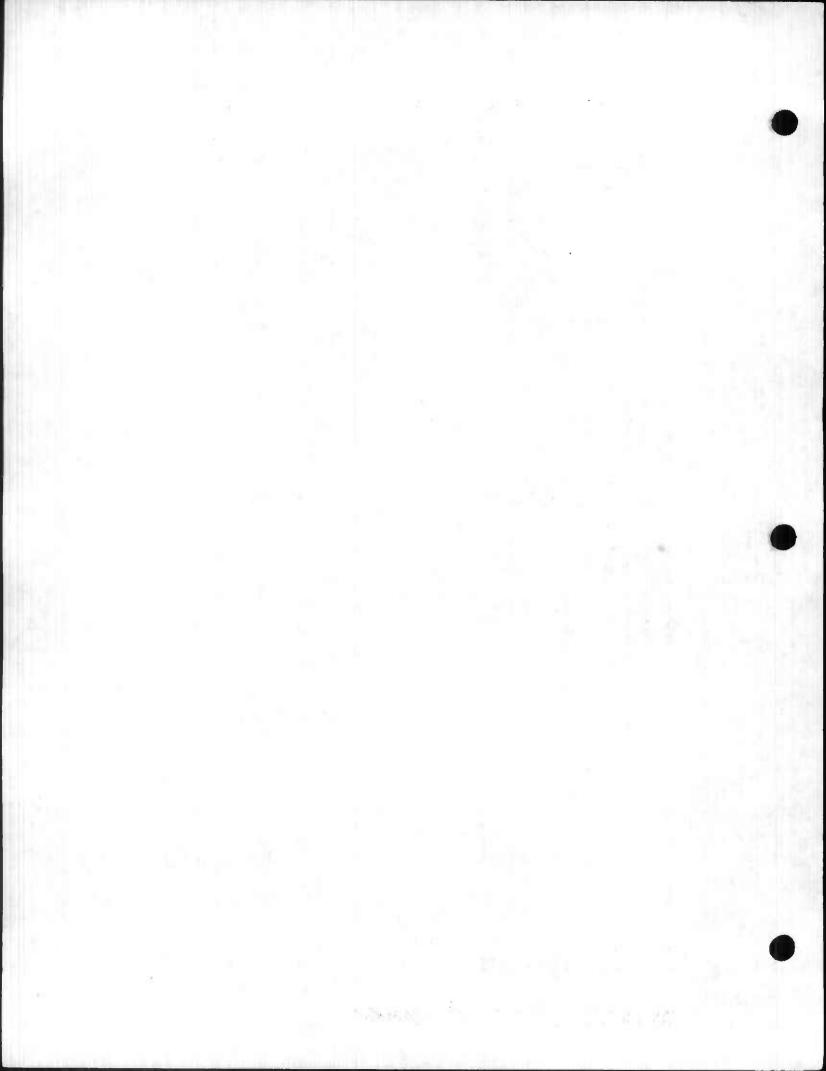
					State of	iviai yiai i				Death	u ivieritai	Reg. No	00	J	1051
	П	Physician	Decedent's Name								JANOPH		y. 21	100 0	3. Time of Death 8:50 AM
		/Medical Examiner	4a Facility Name (I	Inthony Ba	e street and num	nber)			- 4	lb. City, Town,	or Location of I				more
		Laminer	Saint	Joseph	Medica	1 Cent	er				son		В.	artı	more
		Funeral Director	5. Social Security N	1	ex X☐M 2☐F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	Hours A	Ain. (Monti	h, Day, Year	2000	Coun	ace (State or Foreign Iny) / Land
A		E .	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Loc	ation						11	Od. Inside City Limits
		with the Maryla a or 28e-f show be notified at Director	Maryland	N	/A			Balt	imor	·e					1 □XYes 2 □ No
0		vith the Me t or 28e-f s be notified Director	10e. Street and Nur	mber				10f. Zip	Code			10g. C	itizen of W	hat Coun	try?
ri		ral ral	4335 Hami	lton Ave						21206					tates
-	020	urs after death vill, or flame 23s Examiner must by Funeral	11. Marital Status 1 \(\) Never Marri 3 \(\) Widowed	ied 2 Married	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	2X No				lispanic Origin? an, Mexican, Pt Specify:	(Specify Yes ouerto Rican, etc	or No-		- Americ k, White, d	
BAKER	Maryland 21215-0020	ygiens. Ygers. Ar then "neturn It, the Medical. Completed	(Spec	15. Decedent's Edity only highest gra	fucation ide completed) College (1-	-4or 5+)	16a. Deced (Give I life. D	and of wor O NOT us	k done d e retired	during most of	working	100	Col 6		liter 10
14	9	Co marie	17. Father's Name	(First, Middle, Last)			рер	ende		Name (First, M				porting
à	/lan	Mental H Mental H ericed oth wife even To Be		Baker							thleen				
W	lany	2 sho and N is ma	19a. Informant's Ne		Type, Print)		19b. Mailing	Address	(Street	and Number of	Rural Route N	lumber, City	or Town,	State, Zip	Code)
I	≥,	and a	Mr. Neal		Father					n Aven		timore			
MAHER	Baltimore,	H of H		☐ Cremation 3 ☐		State	lace of Dispos emetery, crem	atory or of	her plac		Date 147 (00		ocation - (
-	III.	ritanti njury	4 Donation 21, Signature of Fu	5 Other (Specify		St	. John			ss of Facility	1/17/20	оч нус	ies,	mary	land
	Ba	Depa Impo any i	July	ast	tu	_	Le	eonar 305 H	d J.	Ruck,	Inc. F	imore.	l Hom	e 2121	4
	•	Physician /Medical Examiner	23a Part Enter in shock, or hear shock, or hear shock, or hear shock or condition resulting in death)	(Final		EME PF		JRITY						1	Approximate Interval Between Onset and Death 40 MINS
		executed in end inei-transit Examiner			b	D . 1. 1-			1					i	
.)	68760,	ficete be executed physician and as the buriel-transit edical Examir	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I.		c		as a consequ							1	
TW		eth certific etending p for use es			d						_				
17	Box.	d for u	Part II. Other signifi	icent conditions o	ontellusting to do	oth hut not one	ding in the un	darbina au		on in Dort I	225	Did tohaca		tribute to	the cause of death?
Cholai	, P.O.	es that the death cert igned by the ettendin be deteched for use by Physician/W	Path, Other aight	Cart Coronoris C	orthootaly to dec	aut Dut Hol 1954	mung in the tin	oenying ca	use gr	en ai Parti.	230.		2 XNo		ably 4 Unknown
	of Vitai Records,	been s should									24a.	Was an auto performed?	opsy	ava	ore autopsy findings hilable prior to inpletion of cause death?
	E.	The iev ate hes pege 2										1 ☐ Yes 2	No	1 🗆	Yes 20 No
	/Ita	yaiclen: The is s certificate he director, page To Be Com	25. Was case reference examiner?	red to medical					1=-		Death (Check o	only one)			1.1
	of	Physic crai dire	1 ☐ Yes 2 X		Hospital: 1 In		ER/Outpatient 28b. Time of			4 LI NUISIN	g Home 5		_)
	Division	tal or Attending P rs effer death. al Director: Affer ti led in by the funera Certification:	1- Natural 2 Accident 3 Suicide	5 Pending investigation 6 Could not be	(Month	n, Day Year)	lnjury	M	Sc. Injury Wor	k? Yes 2 □ No	280. Desc	ribe how inju	ary occum	BO	
	DIVI	ns effect at Direct at Direct ind in by	4 Homicide	determined	289. Place 6	of Injury - At ho g, etc. <i>(Specif</i>)	me, farm, stre	et, factory,	, office			ion (Street a r Town, Stat		er or Rura	l Route Number,
		To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the filled in By the filled in Certification of the Certification	29a. Certifier (Check only one)	12 Certifying Ph	ysician: To the baseliner; On the baseliner	sis of examinat	vledge, death ion and/or inve	occurred a estigation,	t the tin	ne, date and pl pinion, death o	ace, and due to ccurred at the t	the cause(s	s) and mar ad place, a	nner as st and due to	ated. the cause(s)
		Within To the Common M	29b. Signature and	title of certifier				29c.		e number 27352		29d. Da	ate signed	(Month,	Day, Year)
			m	orly 1	Hem	15N	>		100			1	-B-	00	
1	1		30. Name and addre	H. BEN	Ompleted cause	of death (Item	23a) (Type, F	ÖSLI	ER	DRIVE,	TOWS				
d		State Registrar	31. Date filed (Mont		Sancy	gistrar's Signa	ture Sp	aks	,						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #5 PER F.H. G780 2-2-2000 WR. Contificate of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician EDWARD** LOUIS BENNETT 9, 2000 2:27 PM January /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Genesis Long Green Nursing Home Baltimore City N/A If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
July 6, 1909 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** XOM 2DF Months Deys Hours Min 218-09-9980 90 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heelib and Mental Hygiens. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or flows traumatic event, its fancies Exercital must be notified. 1 XYas 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1642 East Belvedere Avenue 21239 United States Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Bleck, White, etc. 1 DYYas 2 □ No If Yes, Giva Yeer or Detes: 1 Nevar Married 2 X Married Maryland 21215-0020 1 Yes 2 XNo Specify: þ White 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 9 Salesman Shoe Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles Bennett Celia Larkins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, MD 21234 Mrs. Terry Brouillette / Daughter 8200 Avondale Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other pleca) 20c. Location - City or Town, Steta Department of H Important: If its eny injury or of page. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1/17/2000 Towson, Maryland Hilltop Service Corp. 22. Name end Address of Fecility Baltimore, MD 21214 Leonard J. Ruck, 5305 Harford Rd. Inc. o, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, but only one cause on each line. 23a. Pert1. Enter the distance shock, or heart lands Approximata Interval Between Onset and Deeth Physician /Medical tmmediate Ceuse (Finel disease or condition resulting to death) Snygsin Examiner Physician/Medical Examiner The law requires that the death certificate be executed use es the burial-trans Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting to death) Lest Due to (or es a consequenca of) and Box 68760, Hens Due to (or es a consequence of) P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown our of Vital Records, ρ director, page 2 should be 24b. Were autopsy findings available prior to completion of causa of deeth? Be Completed 24a. Wes en eutopsy 1 Type 2 Din t Yes 21 No this certificate or Attending Physicien: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Naturat after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) determined 4 Homictde To the Hospital of within 24 hours a To the Funerel D 1 Strittying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier completely (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier MU who completed cause of deeth (Item 23e) (Type, Print) & HAPHMI, 82 (N, EN St Souto 308, Ball- mo SHOAIR A 2/201 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar JAN 19 2000

TH

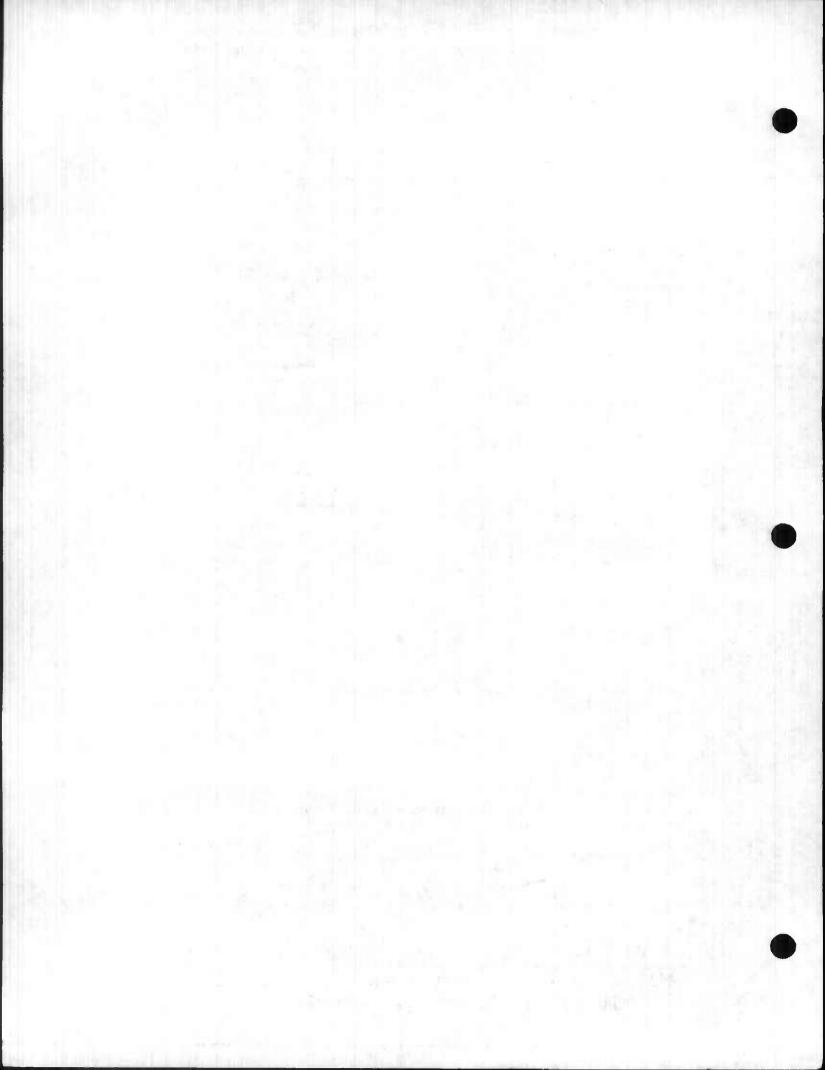


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11

	1. Decedent's Neme (First, M		_		Certifica			2. Date of De		Vers	3. Time of Death	
Physician /Medical	James Edward	Black,	Jr.					JAN.	Day 14, 20	Year 000	2311 PM	
Examiner	4e Facility Name (If not instite UNIVERSITY			11-			4b. City, Town, or BALTIMO					
neral ector	5. Social Security Number 216–86–3894	6. Sex	7. Age	e (In yrs. lest 27	birthday) If Und Month	er 1 Yeer s Days	Hours Min.		ay, Year)	9. Birthpla Country Md •	ice (State or Foreign y)	
by Funeral Director	Usual Residence of Decedent 10a. Stete 10b. Cou	7		10c. City, To	own or Location					100	d. Inside City Limits	
Director		/a			Baltim	ore			74.5		¥EXYes 2□No	
ral Dire	10e. Street and Number 905 N. Roseda	le Stre	et		10f.	21216		10g. Citizen of What Country? USA				
by Funeral	11. Meritel Stetus Never Merried 2 8 3 Widowed 4 Divor	lerried 1 [as Decedent I med Forces? Yes, Give eer or Detes:			cedent of F pecify Cub 2 XXX	dispanic Orlgin? (Sen, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Specil	ca - Americar ick, White, at by: Bla	c.	
Completed	15. Dece (Specify only his Elementery/Secondary (0-1 11th Grade		pleted) oliege (1-4or 5	+)	Ba. Decedent's U (Give kind of life. DO NOT Baker	suel Occup work done use retire	pation during most of wo d)	rking	16b. Kind of B		stry	
Be Co	17. Father's Neme (First, Mide	lle, Last)			Danel		18. Mother's Ne		-			
To B	James E. Blac	James E. Black, Sr. Vern 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Numb										
-	19e. Informent's Neme/Retet Vernita Keitt	onship (Type, Pi		ther	9b. Meiling Address N.	ess (Street Hilto	end Number or Ri on Street	Baltim	ore, Md	State, Zip C 2121	Code) 6	
	20e. Method of Disposition 1XXSuriel 2 Cremeti 4 Donation 5 Othe		el from State	ceme	of Disposition (fatery, cremetory)	r other ple		Jan. 20	20c. Location Baltim			
	21. Signature of Funeral Serv		1	MID			· cu · cu · i					
	22. Name and Address of Facility Nutter Funeral Homes, I 2501 Gwynns Falls PKWY Baltimore, Md. 2 23a. Part 1. Enter the disease, or complications that caused the deeth Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause on each tine.											
r uler	Immediate Cause (Finel disease or condition resulting in death)	a										
fedical Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C			a consequence of							
lan/N		d										
by Physician/M	Pert It. Other algniffcant cond	litiona contribut	ing to death bu	ut not resultin	g in the underlyin	g cause gi	ven in Pert t.		Yas 20 No		the cause of death? ably 4 Unknown	
Completed by								24a. Wa	s an autopsy ormed?	avai	re autopsy findings ilable prior to apletion of cause	
jdmc								10	Yes 2 No		éath? Yes 2□ No	
BeCc	25. Was case referred to med	ical					26. Piece of De	ath (Check only			. 30 400 110	
To B	exeminer?	Hospit	el: 1 🗌 Inpatie	nt 2XXR	Outpatient 3	DOA ON	hor	Home 5□Res		her (Specify))	
Certification:	E LI AGOODIN	estigetion \	a. Date of Injur (Month, Day	y Year)	b. Time of fnjury	28c. Inju Wo	ry et irk? Yes 2 No	Surje		HOT 13	y police	
rtific	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	and not be amined 28	e. Plece of Inju- building, etc	c. (Specify)	, ferm, street, fac	tory, office		City or To	(Street and Num own, Stete)		. 1	
edicai Ce	(Check only YY Medi	cal Examiner: C	on the basis of	of my knowled examinetion			me, date end ptec	a, end due to the		anner as sta	ited.	
Medical Certification:	29b. Signature and title of cer	A	nd menner ste				se number		29d. Date sign			
	> launi	5 me	Yhu	L			.C.M.E		-	15 ,2		
	30. Name and address of personal Control of the con	on who complet				met	, Baltimo	me Mer	vland 2	1201		
								CHAL	- ALLENA .			

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Crowder **Physician** Teressa /Medical JANUARY 15 2000 08:23AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL
5. Social Security Number | 6. Sex | 7. Ag BALTIMORE CITY If Under 1 Year 8. Date of Birth (Month, Day, Year) 07 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min Country) M.D. 1□M 2\ F 39 60 Director 214-84-6041 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location must be notified at 10d. Inside City Limits TY es 2 No Director MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. Items 23s 842 Evesham Ave Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiens. Important: if Nem 27 is marked other than "natural", or han any injury or other treumatic event, the Medical Expension Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baltimore City Health Dept. Counselor 12th grade 2yrs 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley L. Medley Herley R. Crowder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1229 Bermuda Lakes Lane, Kissimmee Fl. 34741 Veronica Perry- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 1/20/2000 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore Md Fert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head tailure. List only one cause on any time. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel Mycobacterium avium infection 3 months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Syndrome Vears Acquired immuno de ficiency physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 1 WEEK tailure Acute Box 68760 renal Physician/Medical Due to (or as e consequence of): 980 The law requires that the deeth ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the the signed by t 1 Yes 2 No 3 Probably 4 WUnknown malnutrition ģ 24b. Were autopsy tindings available prior to completion of cause of death? pancytopenia Completed 24a. Was an autopsy performed? 105 page 2 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital a or Attending Physicien: T anter death. I Director: After this certificat ad in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Metural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours all To the Funeral Di complished lined in edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M FES - 000 January 15, 2000 Odael Ow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Baltimore, Maryland 21287 Matthews Chacko 601 North Wolfe Street

HMH 16 Ray 6/95

State

Registrar

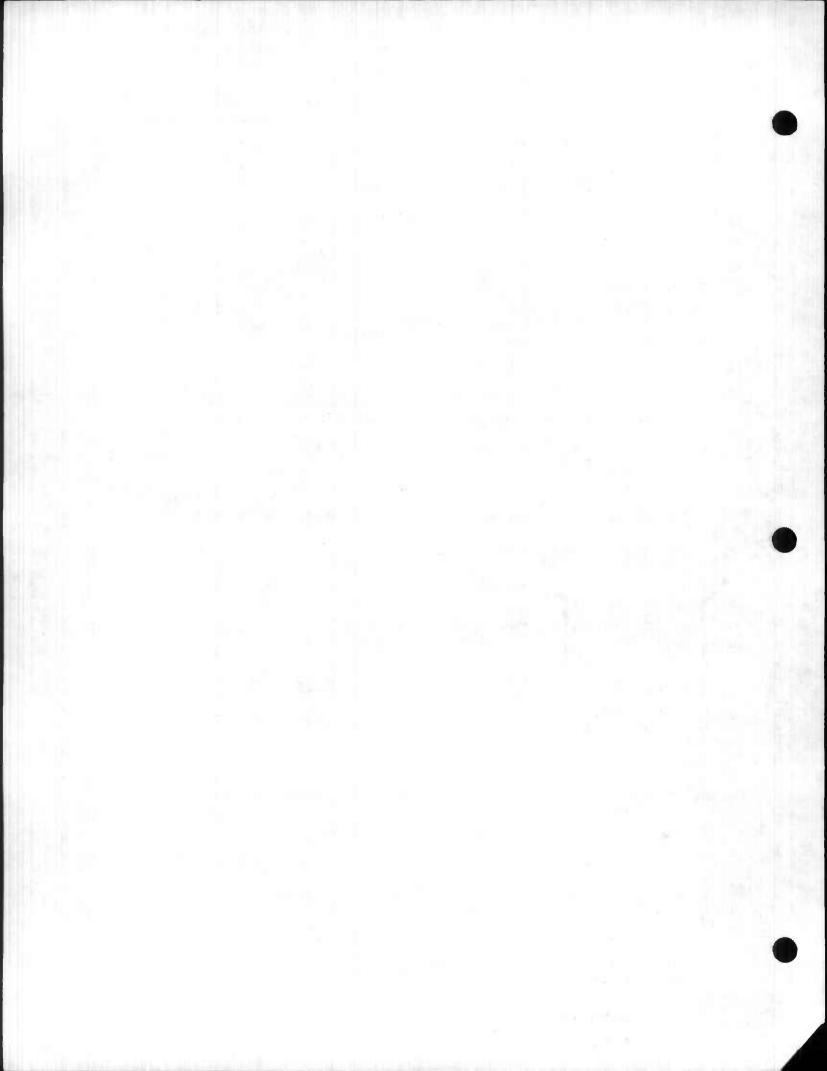
JAN 1 9 2000

31. Date filed (Month, Day, Year)

ouks

32. Registrar's Signature

Sereva



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yes **Physician** VINCENT CINQUEGRANI, SR. 2000 1200 JANUARY /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 900 (ASUN AVE BALTEMAR ST. ALNES HEALTH CAME | Hunder 1 Year | Hunder 24 Hrs. | 8. Dete of Birth (Month, Day, Year, 03-03-1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F MARYLAND 220-12-4791 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examinar must be notified at MD BALTIMORE ARBUTUS 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 938 GROVE HILL ROAD 21227 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. al Hygiene. other than "natural", or he 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHROME PLATER MANUFACTURING permit. Pages 1 and 2 should be flied v Department of Health and Mental Hygiel important: if itam 27 is marked other th any highry or other traumatic avent, the 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) ANTHONY CINQUEGRANI MARIE ALIMO 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informant's Neme/Relationship (Type, Print) MARY E. CINQUEGRANI SPOUSE 938 GROVE HILL ROAD, ARBUTUS, MD 01-21-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 \$\infty\$ Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CEMETERY BALTIMORE, MARYLAND 2000 21. Signature of Funeral Service Licen-22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE, BALTIMORE, MD 21229 suc 23a. 7ft. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final MYOLARDIAL disease or condition resulting in death) Examiner Physician/Medical Examine YEARS ALTERY DURAIR (ORONAR) attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 94 signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 2 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after Funeral Directal States 4 ☐ Homicide 6 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ATUN ROPNE-1 HEAUTH (ARE mar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 16 Rev 6/95

OBIGU

9

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month :10 Pm JESSE CANNON ian 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death ST. AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. lest birthday) 9. Birthplace (State or Foreign 1⊠M 2□ F Months 68 215-28-2312 Yrs. 03-24-1931 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE CATONSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 WORTHMONT ROAD 21228 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Maritai Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY ADM. Elementary/Secondary (0-12) College (1-4or 5+) POLICY WORK U.S. GOVERNMENT 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) CANNON Α. FLORENCE E., MILES 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 208 WORTHMONT RD., CATONSVILLE, MD FRANCIS Ρ. CANNON **SPOUSE** 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 01-17 1 N Burial 2 Cremation 3 Removal from State MARIOTTSVILLE, MD CREST LAWN CEMETERY 2000 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 Rulmo Part 1. Enter the disease or complications thet caused the brieft. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Non Small cell hung Concer 4 weeks Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? 25. Was case rafarred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dev Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1/MNatural 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) Woulde, MD

To the I within 2 State Registrar

31. Date filed (Month, Dey, Year)

YUTOMBO

32. Registrar's Signature

ST

146704

ACRES HOSPITAL

12

DHMH 16 Rev 6/95

Physician

/Medical

Examiner

Director

Funeral

þ

0

Examiner

Physician/Medical

þ

Completed

Be

Certification:

edical

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinar, must be notified at

2 should be filed within 72 hours after and Mental Hygiena.

permit. Pages 1 and 2 Department of Haalth a Important: If Item 27 le

Physician /Medical

Examiner

and

physician

the

88 USB

signed t

peeu

has certificata

this

after death. Director: Aft

of Vital

Attending Physiclan:

ò

certificate be axec Box 68760,

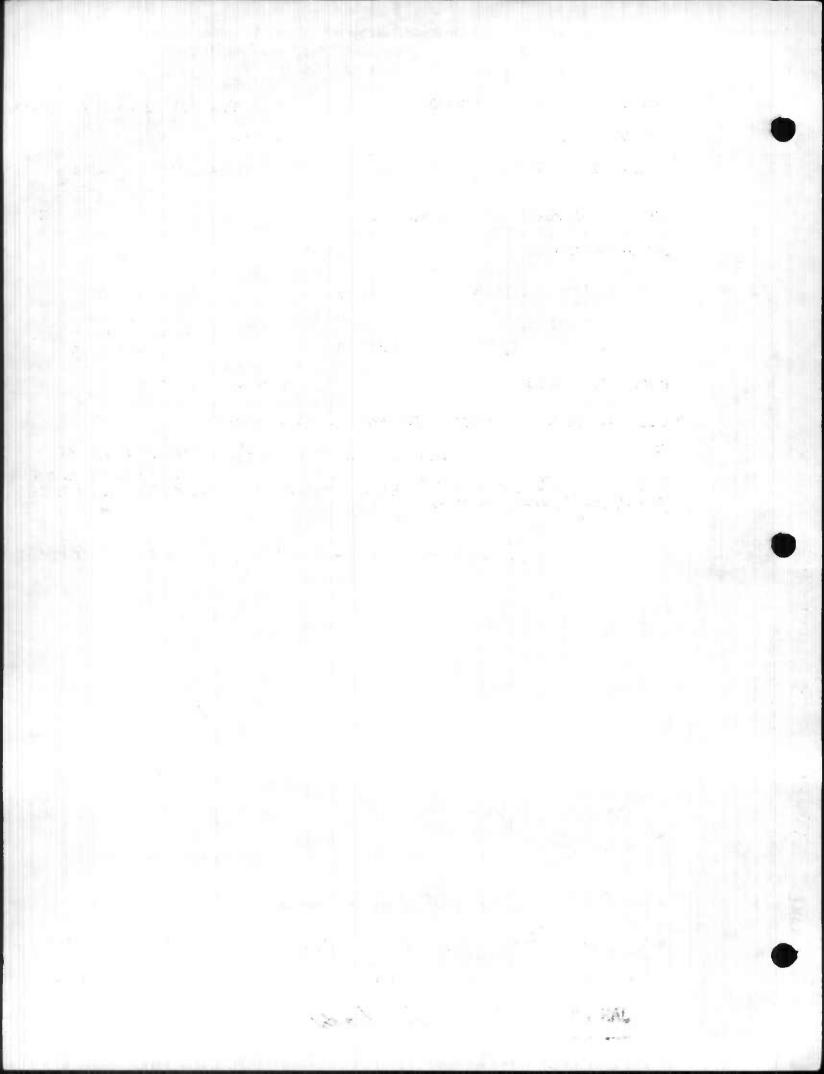
other

ò

any injury once.

altimore, Maryland 21215-0020

2 24 the Maryland



DHMH 16 Ray 6/95

State

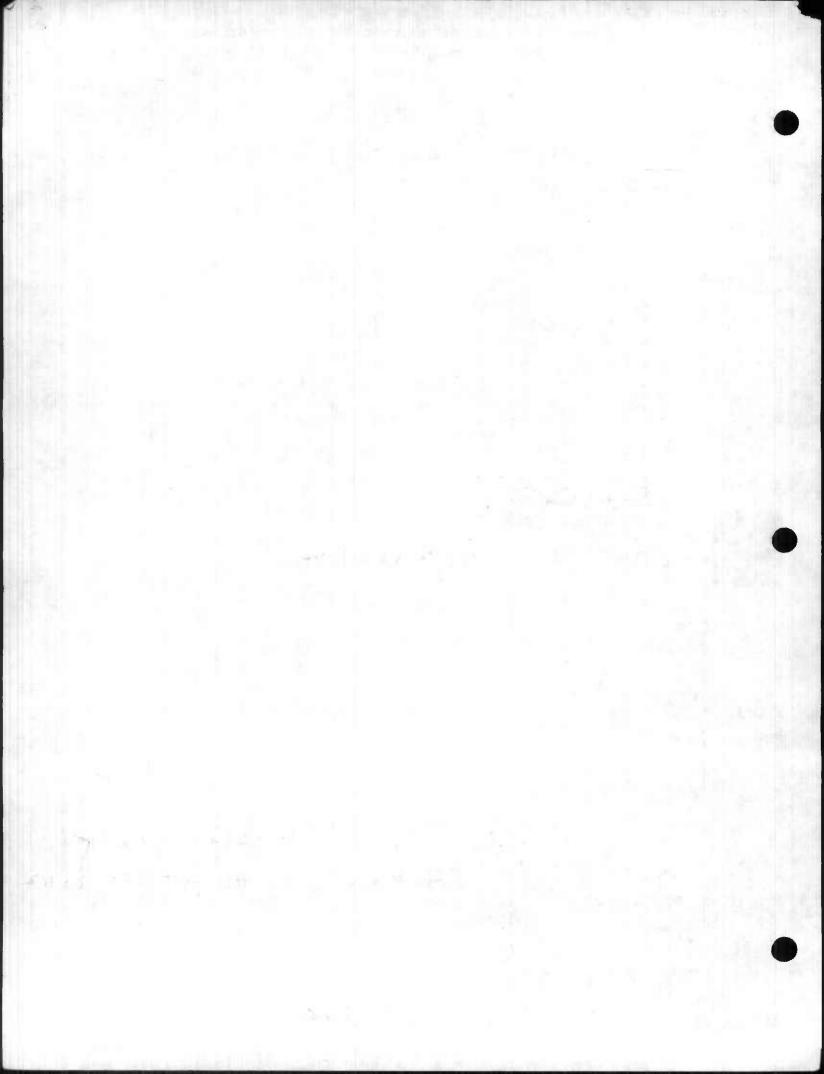
Registrar

Mu a

32. Registrar's Signature

Geneva

111 Penn Street, Baltimore, Maryland 21201



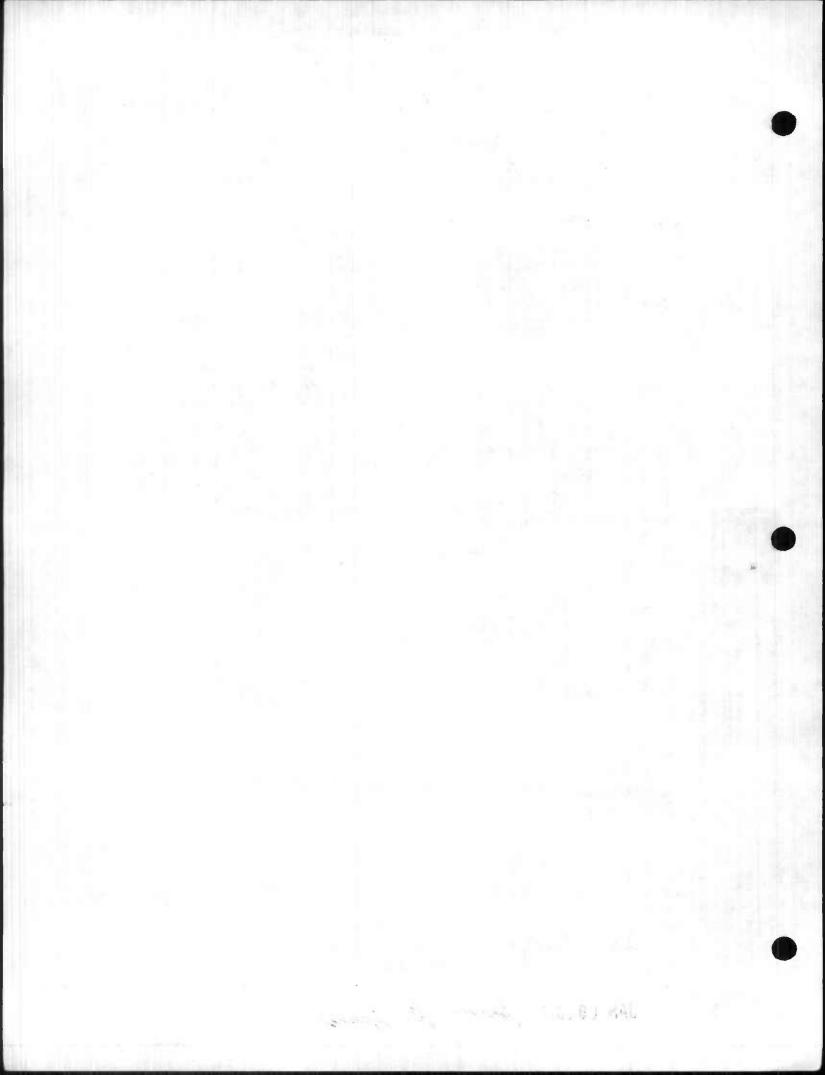
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Flizabeth 2000 JANUARY /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mercy MARIS BAITIMORE
If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Year) 1405 5. Social Security Number 6 Sex 7. Age (jh yrs. last birthday) Birthplace (State or Foreign Quntry) **Funeral** 32-15 Days 1 M 2 KF Months Director IRGINIA Usual Residence of Decedent 10a Stete 10b Count 10c. City, Town or Location 10d. inside City Limits nem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at BAHIMORE 1 Yes 2 No Director TARY land none the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ARROllton 21217 Auc Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 20 No Baltimore, Maryland 21215-0020 Ayro American Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) OWN Home Home maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be COCKREI Anne White Tobers 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Winston Ave-BAHO, Md 21212 // Dete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removel from State LAR Scholine, 4 ☐ Donation 5 ☐ Other (Specify) Cion 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility NANCY M. WALLACE St. Sp. Himore, manyland 3405 W. FRANKLE offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the respiratory one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner () ue to (or as a consequence of) Examiner the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. attending physician Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 → Unknown been signed by should be detac 1 ☐ Yes 2 ☐ No Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy parformed? completion of cause of death? page 2 s 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? AT MERCY Be 26. Place of Death (Check only one) Ste 1/A Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of injury 28c. Injury at Work? Medical Certification: Director: After 5 Pending investigation or Attanding Matural 1 Yes 2 No after death. 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral D the Hospital Lip Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 10 U 30. Nema and address of person who com éted cause of death (Item 23a) (Type, Print) SY 31. Date filed (Month, Dey, Year) Registrer's Signeture State JAN 1 9 2000

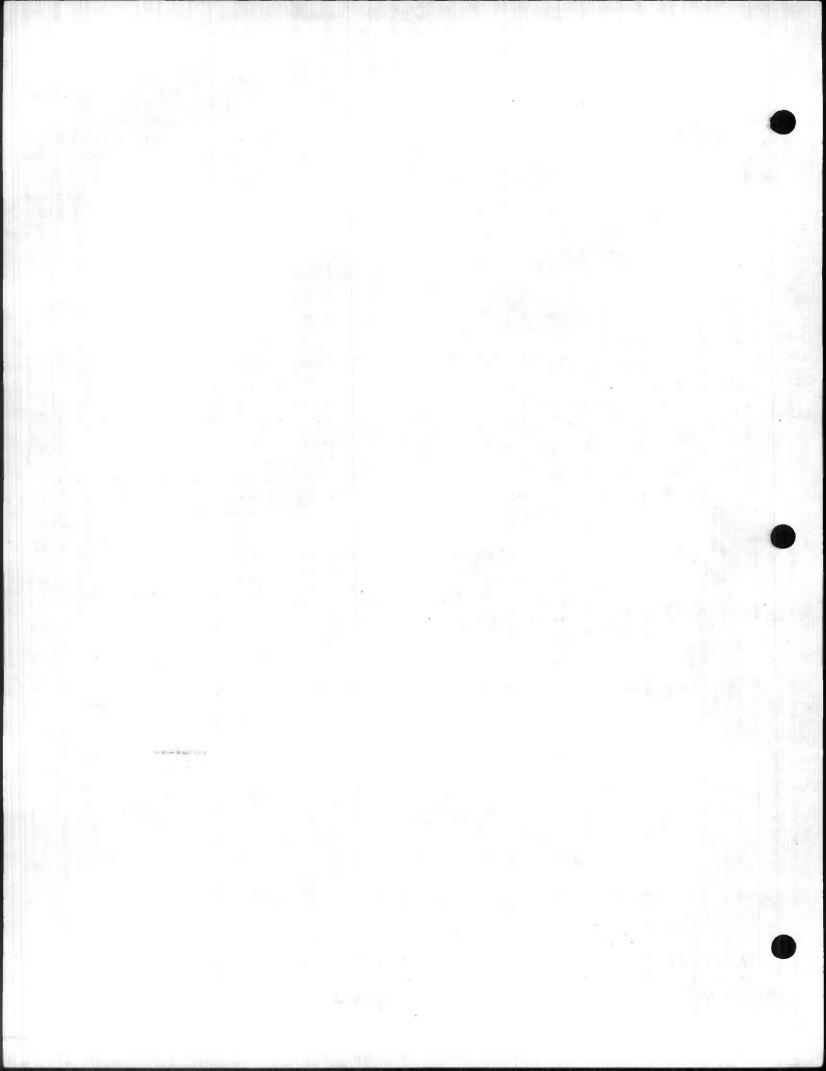
DHMH 16 Rev 6/95

Registrar



	1
60,	
68760,	
Box	
of Vital Records, P.O. I	
Ś	
ord	
leco	
F	-
## JE	
5	•
-	i
0	•
Division	
0	
	-

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8.100 Month Physician 134 2000 Frank Raymond Chick Jan /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Anusdel North Anundel Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1₽M 2□ F 49 220-56-9549 Yrs. Director Dec, 28, 1950 Md. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. r than "natural", or Nerre 23s or 25s-f sho the Medical Examiner must be notified at Md. 1 Yas 2 No Director Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7800 Waterview Dr. 21226 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 12 Yas 2 No If Yes, Give Yeer or Detes: 1X Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ KNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i filed within 7 I Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Construction Electricion 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 8 ould be Mental Frank Chick Ella P. Snyder 2 19s. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is a any injury or . P.O. Box 266 Frisco, North Carolina 27936 Joy Reinhardt/sister altimore, 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Dete cemetery, crematory or other place) **P**☐Burial 2 ☐ Cremetion 3 ☐ Removel from State Glen Haven Mem. Park 1/17 Glen Burnie, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Home P.A. 21. Signature of Funeral Service Licensee krome 4001 Ritchie Hwy. Balto., Md. 21225 momeouren 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Hepatic Failure
Due to (or as a consequence of): /Medical Immediate Cause (Final 6 month disease or condition resulting in deeth) Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last physician s the burial an/Medical attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Š 1 Yas 2 No 3 Probably 4 Unknown be de Š 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata 8 25. Wes case referred to medical 26. Placa of Death (Check only one) Hospitel: 1 SQnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 🕼 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signeture and Wile of certifier 29c. License number Jan 13 th 2000. D44973 30. Name and address of person who completed cause of death (Hom 23a) (Type, Print) GURMEET.S. SAWHNEY,MD 328 Hospital Drive Suit 202, Glen Burne, MD 21061 31. Date filed Mahr, Paygran 00 32 Registrare Signeture Docks State Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Time of Death Alfred Year **Physician** 19 y 04 00 2000 JANUARY 13 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-3/-43 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Hours 56 Yrs. 212 - 41-1937 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No Director MD BALLIMORE 28a-f 10a. Street and Number 10g. Citizen of What Country? must be n Berns 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ■ Never Married 2 Married altimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COOK 12 permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: if New 27 is marked other any Injury or other the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be BARBRA FLOXD ALBERE 2 COTTREL 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St, BALTO, MA 2 200. Location - Offy or Town, State WHShING ton 201 MNETT 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State KING 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4600 LIBERTY HP15414 AVE, BATTIMET, MO 31201 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel infection disease or condition resulting in death) Examiner obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last tes · diabe Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contribute to the cause of death? 1 Yes 20 No Š 3 Probably 4 Unknown obstruction signed b by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hypertension disease vascular To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medicel examiner?

1 Yes 2 No 8 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES -000 13,2000 la Waler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rav 6/95

Walker-Ford

31. Date filed (Month, Day, Year)

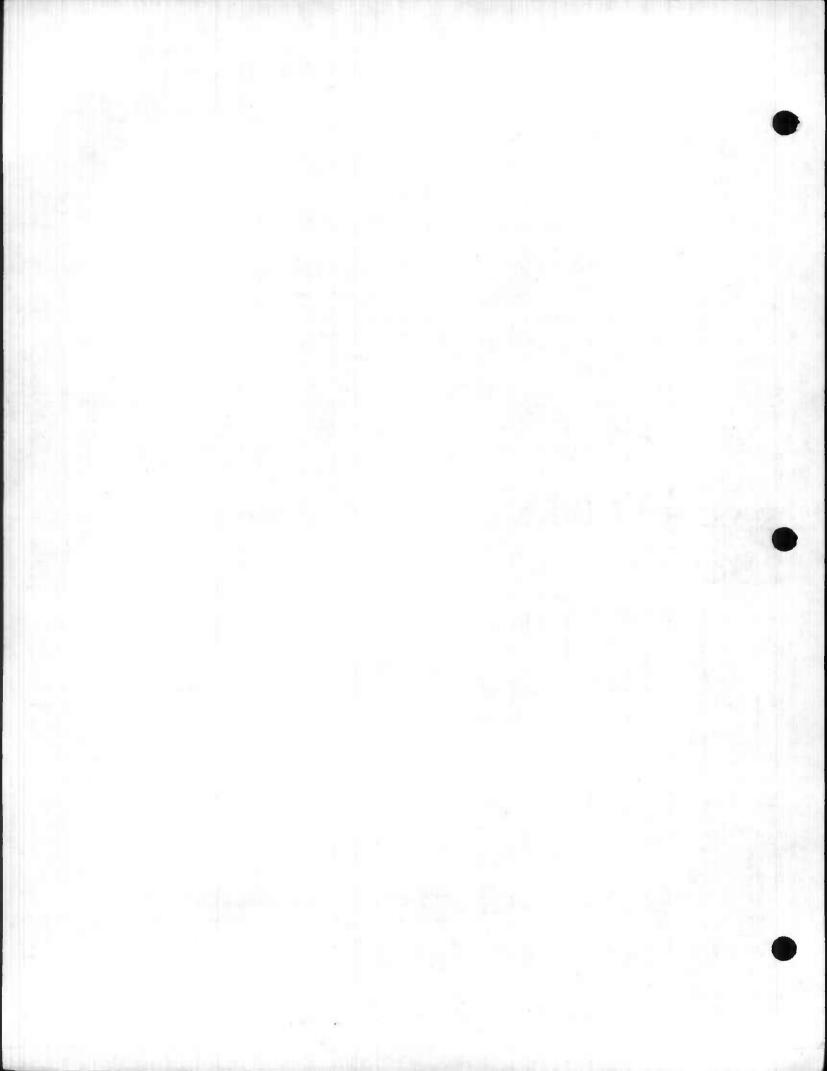
Tower Building

32. Registrar's Signature

110

19

, Johns Hopkins, Ballimore, MD 21205



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 16,2000 Year JAN. CROWDER 0952 DOROTHY 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death BON SECOURS HOSPITAL BALTIMORE | Months | Deys | Hours | Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) | Property | 1931 | NORTHCAROLINA 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Months 1□M 2□F 68 Yrs. 214-30-6624 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 N. MONROE STREET 21217 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Biack, White, etc. AFRO-AMERICAN 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) 10TH SEAMSTRESS LONDON FOG 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) BOOKER T. BRIDGES THEALOR PIGATT 19e. fnformenf's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1530 RALWORTH RD.BALTO, MD. MICHAEL MC CORMIC / SON 21218 20b. Place of Disposition (Name of cemetery, cremetory or other place) GARRISON FOREST VETERANS CEM.OWINGS MILLS, MD. 20a. Method of Disposition 1 Qurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23e. Pert 1. Enter the disease, or complications that caused the deeth of not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21213 Approximate Interval Between Onset end Deeth Myo cardial tmmediate Cause (Finat disease or condition resulting in death) Sequentielly list conditions, if any, teeding to immediate ceuse. Enter Underlying Cause (Disease or injury ialle that initiated events resulting in deeth) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide

physician and the buriel-transit 88 esn or Attending Physician: After this s efter death.

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Medical Examener must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic sware.

Physician

/Medical

Examiner

Physician/Medical Examiner

g

Completed

Be

Certification: To

Medicai

29a. Certifier

(Check only one)

altimore, Maryland 21215-0020

the Maryland

death

Division of Vital Records, P.O. Box 68760,

page 2 24 hours e Hospital within 2

> State Registrar

31. Date filed (Month, Dey, Year) JAN 1 9 2000

29b. Signature and title of certifier

Ledwish

29c. License number

1 Decrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year)

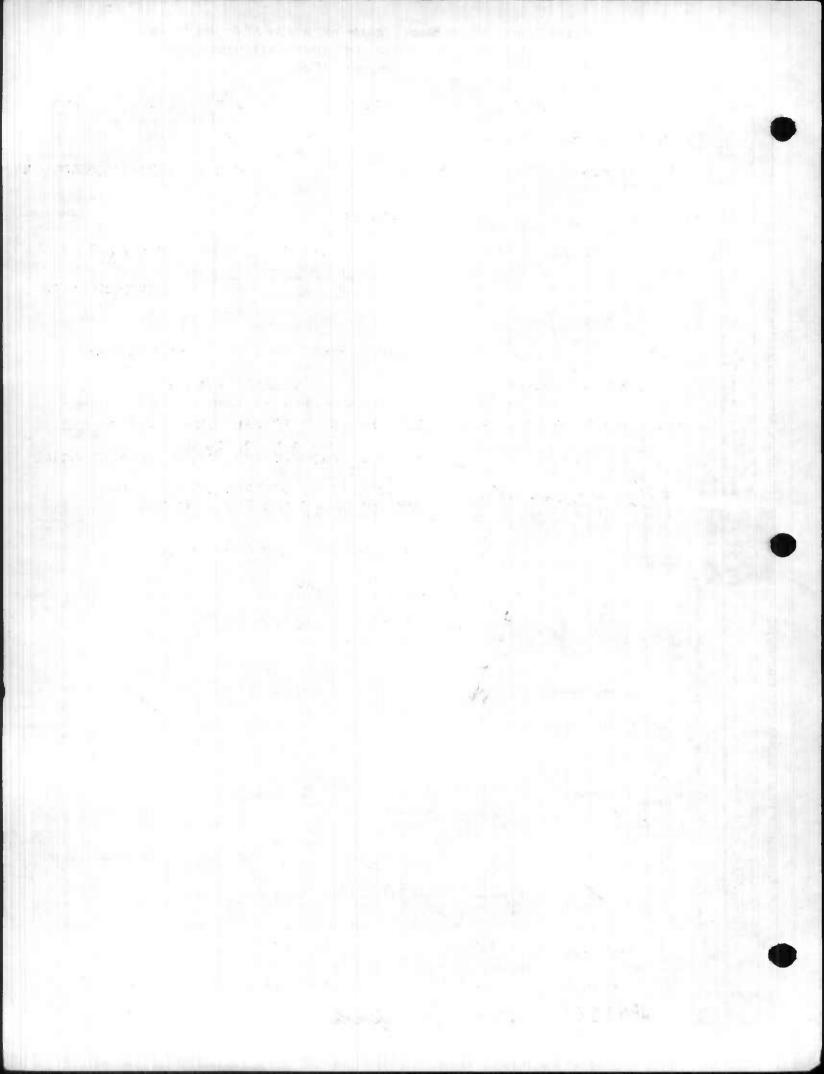
30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print) Washington

Blud.

BALTIMORE, MD-

32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea **Physician** Carrie V. Cropsey JANUARY 17 2000 3:10 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bel Air Mariner Health Bel Air Harford 5. Social Security Number 218-36-4987 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1□M 2♥F 97 Yrs. Director March 10, 1902 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show the Medical Examiner must be notified at the Man MD Harford 1 ☐ Yes 2 No Director Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 E. MacPhail Rd United States 21015 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritai Stetus Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ Year or Dates: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Hame Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental merked or Joseph Courtney Horseman Department of Health and I Important: If Nem 27 is me 19a. Informant's Name/Reletlogship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Ann Appleby daughter 1704 Unit 1C Rich Way Forest Hill, 1. MD 21050 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremetion 3 Removal from State Baltimore Cemetery 1-18-00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 23 Name and Address of Facility CAFA Stephen D. Londmann, P.A. 21. Signature of Funeral Service Lightse 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed usa as the burial-tran Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Due to (or as a consequenc Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To the funeral 28a. Date of Injury (Month, Day Year) 27. Mennes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier (Check only one) 1 Cortifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medicai completely 9 29b. Signeture and fitte of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRPHAIL RO BEL AIR MO 21014

DHMH 16 Rev 6/95

State

Registrar

TUNCAN

JAN 1 9 2000

31. Date filed (Month, Day, Year)

UBERT

Q

ROPSEY

615 W-

32, Registrar's Signeture

LILLAN MICHAIL

1. Decedent's Name (First, Middle) LILLIAN 4a Facility Name (If not instituting the state of the				Certifica				leg. No.		
4a Facility Neme (If not instituti	NA 7A TO						2. Dete of Dee		3. Time of Death	
4a Facility Neme (If not instituti	MAE	CURTI	S				Month	Day 2	2000 3:13 An	
ITHIAT 14	n, giva stree	t and number)				4b. City, Town, o	or Location of Death		of Death	
02.01.2	Uspi-	tal ~	1 Bal.	tmon		1 - 0 - 1	me Ci	N/A		
5. Social Security Number	6. Sex 1 ☐ M		lo yrs. last birti	Month	ar 1 Yaar s Days	If Undar 24 H		Year)	Birthplace (State or Foreig Country)	
228-28-9250 Usual Rasidence of Decedant		-90.	76	rs.			AUG 3	1923	VIRGINIA	
10e. Stata 10b. Count		1	0c. City, Town	or Location					10d. Inside City Limits	
MARYLAND N	'A		BAL	TIMORE	CITY				1XXYes 2□No	
MARYLAND N, 10e. Streef and Number				10f. 2	Zip Coda		1	log. Citizen of W	hat Country?	
	TRAILITE				2121	5		U.S.	Δ	
3707 BELLE A		Ves Decedent Eve	er in U.S.	13. Was Dec			(Specify Yas or No-		- American Indian,	
3707 BELLE A	A	Vmed Forces? ☐ Yes 2₹XNo		If Yas, sp	becify Cubi	sn, Maxican, Pu	arto Rican, atc.)	Biack	k, White, atc.	
3 ☐ Widowed 4 ☐ Divorce		Yas, Giva reer or Dates:		1 🗆 Yes	2/XXV0	Specify:		Specify:	BLACK	
15. Decede	t'a Educatio		16a.	Decedent's Us				16b. Kind of Bus	siness/Industry	
(Specify only high Elemantary/Secondary (0-12)	1	npieted) Collega (1-4or 5+)		life. DO NOT	vork dona usa ratire	during most of w d)	vorking			
15. Decede (Specify only high Elemantary/Secondary (0-12) 7th grade				HOUSE	WIFE			DOME	STIC	
17. Fathar's Nama (First, Middle	Last)						ama (First, Middle,		a)	
HORACE EAST	HORACE EASTER					VIRGI	NIA EASTE	R		
19e. Informent's Name/Ralation	19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or To									
Jessie Curtis	'Husba	-				venue, I	Baltimore			
20e. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata									City or Town, Stata	
4 Donation 5 Other (1	WOOD	LAWN CI	EMETE	RY	1-22-00	BALTIMO	DRE, MARYLAND	
21. Signature of Funeral Service	Licenses	1		22. Nama	and Addra	ss of Facility	COMMINITO	v FIINEDA	AL HOME PA	
Markara	W-1	nows				ORTH AVI		I FUNERA	ID HOME IA	
Pert1. Enter tha disaasa, o shock, or haart failura. Lis	complication	ons that causad th	a daath. Do n					rast,	Approximeta Intarval Batween	
				0					Onset and Death	
Immediate Cause (Final diseasa or condition		Isch	lomic	, Do	we	1 de	Heare			
rasulting in death)		Du	e to (or as a c	onsequance o	r):				Į.	
Sequentially list conditions,	b									
Sequantially list conditions,		Du	a to (or as a c	onsequence o	f):					
causa. Entar Undarlying	c									
thet initieted evants rasulting in death) Last		Du	a to (or es e c	onsequence of	f):					
- W	d								1	
5								4		
Cause (Disease or injury) thet initieted evants rasulting in death) Last Pert II. Other significant condit	ons contribu	ting to death but r	not rasulting in	tha undarlying	g causa giv	ven in Part I.			tribute to the cause of death	
							101	fes 2□No	3 Probably 4 Unknow	
							24a. Was a	an autopsy	24b. Ware autopsy findings	
								med?	evailable prior to completion of causa	
								1-	of death?	
							1 U Y	~	1 Yes 2000	
25. Was casa rafarred to medic examiner?	Hospi	ital: (A			Oth	ar.	Death (Check only or			
		Inpatient		patient 3□ I ima of	DUA	4 Nuising	Homa 5 ☐ Rasid	ance 6 ∐Otha ow injury occurre		
1 Natural 5 □ Pend		Ba. Data of Injury (Month, Day Y	(ear) In	jury	28c. Injui Wo	rk? Yes 2 ☐ No				
invas	not be	Be. Place of Injury	- At home, far		orv. office		28f. Location (5	Street and Number	er or Rural Routa Number,	
2 Accident invas 3 Suicide 6 Could	unad 122									
207100100111	nined 28	Be. Place of Injury building, atc. (Specify)				City or Tow	n, State)		

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month TARY, Year) 2000

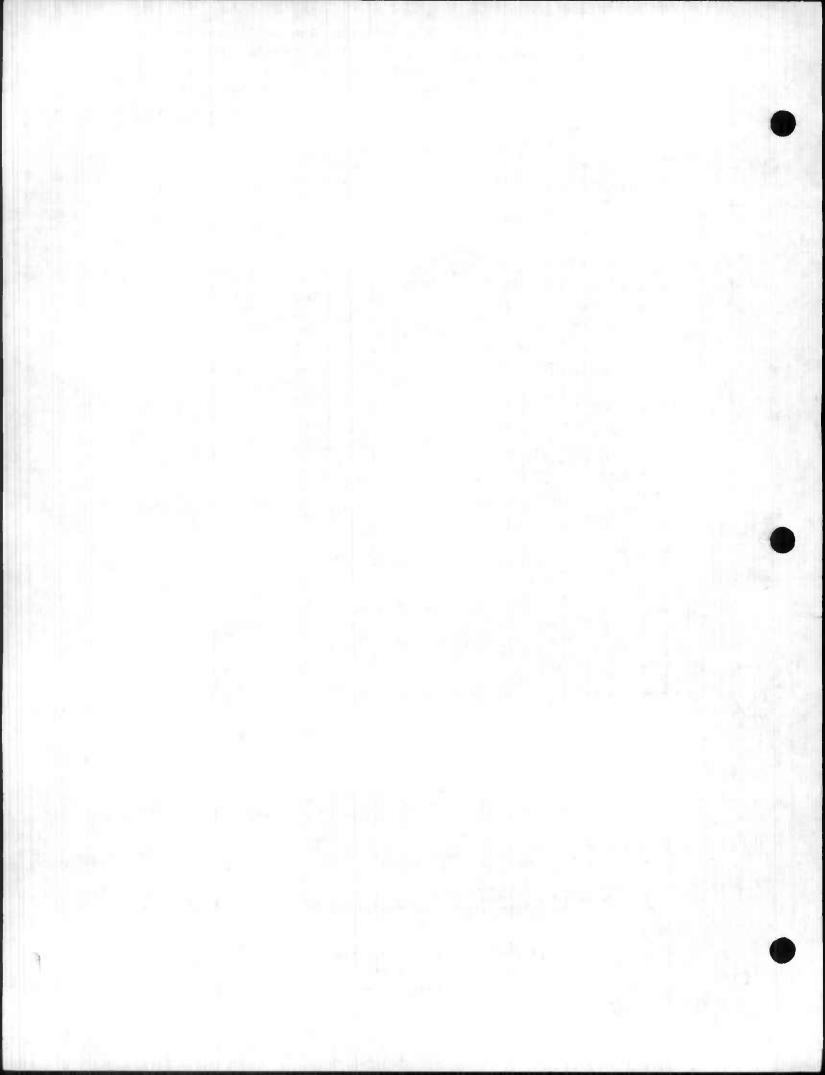
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

TWIT House & Baltmare

31. Data filed (Monty Day, Year) 2000 32. Registrary Signatura

April 19 2000 April 19 20

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Yaar Month **Physician** 12:15 AM COOPER 2000 **EVELYN** M. JAN /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE 1638 FOREST PARK AVENUE If Under 1 Year | Months Days If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) MAY 29 1951 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 1 M 2 XX 48 Yrs. MARYLAND 214-58-8165 Usual Rasidence of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits tXXas 2□No Director MARYLAND N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1638 FOREST PARK AVENUE 21207 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 You If Yas, Giva 14. Race - American Indian, Black, Whita, atc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Nevar Marriad 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) HOUSEWIFE DOMESTIC 10th grade 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be WILLIAM H. GRAVES SR EVELYN HOWARD 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Bernard Cooper/Husband 1638 Forest Park Avenue, Baltimore, Maryland 21207 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stala 15☐Burial 2 ☐ Crametion 3 ☐ Ramovet from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 1-19-00 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service License 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset end Deeth Immediata Causa (Finat Preumonia disaasa or condition resulting in death) week Due to (or as a consequence of): Examiner e Tastatic lung Camera CAR Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequented of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Sarcoidosis ulmonary þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2 No 1 Yas 2 No 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) 1□ Yas 2□ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturat 2 Accidant 5 ☐ Panding 1 □ Yes 2 □ No Invastigation 6 Could not be datarmined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death certificate be executed Box 68760 P.O. Records, Division of Vital Physician: or Attending death. after death Director:

Funeral

Director

288-1

b Berrie 23a

'natural', or

hours after

filed within 72

Pages 1 and 2 should be nent of Health and Montal.

Department of Health at Important: If Item 27 is any injury or other trau 000s.

Physician /Medical

Examiner

lcian and burial-transit

physician s the buriel

3

should be

page 2

this

Affer

24 hours a Funeral C

within 2 e fa

0

filled in by

completely

Medical

29a. Certifiar

(Check only one)

29b. Signeture end titta of certifian

AUSTIN

31. Data filed (Month Pay) YOr) 2000

DOULE

.

Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. License number

123809

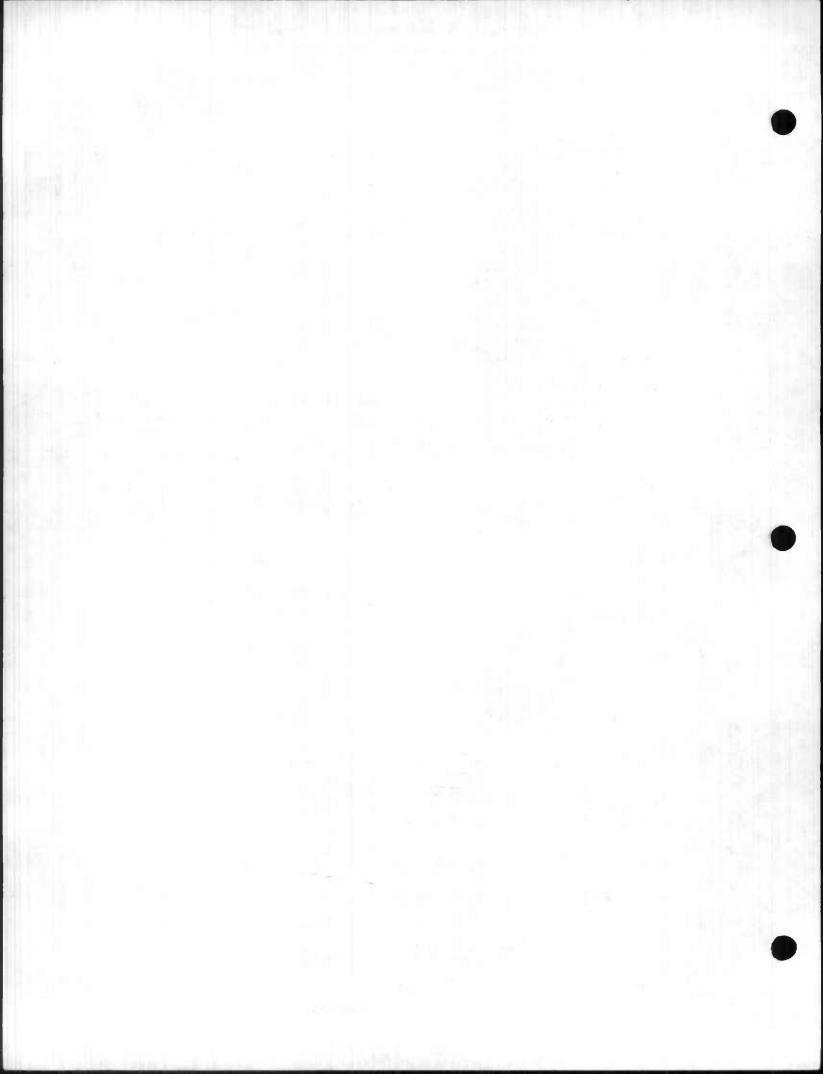
29d. Data signed (Month, Day, Year)

Carcer Center, 22 S. Greeve ST. Baltime Ma

GREENEBAUM

who completed causa of death (ttam 23a) (Type, Print)

M. A. GRES



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

			Certi	ficate of	Death		Reg. No.] [11065
Physician	1. Decedent's Name (First, Middle, Las	ecdore i	Dolche	(2. Date of De Month Januar	Day	Year 000	3. Time of Death 9:45PM
/Medical Examiner	4a Facility Name (If not institution, give		7 (() ()		4b. City, Town, or L	J			7.,0
Examiner	Charlestown Care				Catonsvil	le.		imor	e
Funeral	Social Security Number 6. Security Number			If Under 1 Year		8. Date of Birt (Month, Da	h v Veerl	9. Birtho	place (State or Forei
Director	LIL OI 1250	RM 2□F 83	Yrs.	noitins Days	TIOUIS WILL.	August	18,1916		"Maryland
how how	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Local	lion				1	0d. Inside City Limi
h the Maryla Lindiffied at frector	Maryland Baltimo	re	Timo	nium					1 ☐ Yes 2 ∏ N
# 0 % C	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
ath w	1612 Pot Spring R			210			United		
urs sher death of the state of	11. Marital Status 1 □ Never Married 2 ☒ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 [XYes 2] No if Yes, Give Year or Detes:		s Decedent of es, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	k, White,	en Indian, etc. ite
Ical Ital	15. Decedent's Ed (Specify only highest gra		16a. Deceden	it's Usuel Occu	pation	rina	16b. Kind of Bu	siness/In	dustry
ed within 72 ho yglene. wer than "naturn it, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	during most of work ed)	""9			
Co Margar		1	Audi	tor	T		Goverme		uditing
B state	17. Father's Neme (First, Middle, Last)	h			18. Mother's Nem				
To To		hur Delch		A 44 (O	Susie	May	Kinne		0-4-1
mary joint at 12.10-00.00 d 2 should be filed within 72 hours at th and Marstall typisment from "natural", or the marked other than "natural", or traumatic event, the Medical Exam To Be Completed by f	19a. Informant's Name/Relationship (7) Edwin G. Delcher/				it end Number or Ru ing Road		tum, Mar		
* 5 5 0 5	20a. Method of Disposition		Plece of Dispositi	on (Name of		Date	20c. Location -	,	
0 = 0 = 0	1 Durial 2 Cremetion 3		cemetery, cremet			1/10/200		-0	
mit. Pages 1. partment of Hs contacts if Item y Injury or oth	4 Donation 5 Other (Specify 21 Signature of Funeral Service Licen		oudon Par	lame end Addr		1/10/20	o baiti	more	, Marylan
P C C C C C C C C C C C C C C C C C C C	MUDO	10	Hu	bbard :	Funeral Ho kens Aven				
Physician /Medical Examiner	Immediate Cause (Finel disease or configure in the disease or condition resulting in death)	My		0 =	InSarct				Intervel Between Onset and Death
P = C		b						i	
cate be executed physician and a the buristransit edical Examiner	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conseque	nce of):					
tificate be associated by the burlette as the burlette Aedical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
ificate be g physicia as the bur	resulting in death) Last	Due to	(or as a conseque	nce of):				i	
ath certification attending for use as		d							
death ce attending of for use	Dad II Other similar and an affaire			4.4		L ann Distr			
Physical Phy	Part II. Other significant conditions co	ntributing to death but not r	esuiting in the unce	enying cause g	iven in Pert I.			3 Pro	bebly Dunkno
equir sens souid						24a. Wes perio	en autopsy med?	av	ere autopsy tindings allable prior to impletion of cause death?
The law rate has by page 2 st						10	res DA No		☐Yes 2☐ No
elcian: The certificata lirector, pag o Be Co	25. Wes case referred to medical				26. Plece of Dee		- 1		
F = 0	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA	ther	ome 5 Resid		er (Specil	(y)
tal or Attending Physical arter deeth. al Director: After this ied in by the funeral did Certification: To	27. Manner of Death Natural 5 Pending 2 Accident investigation		y 28b. Time of 28c. Injury at 2			28d. Describe I	how injury occur	ed	
or Attending to the doesh. I Director: After d in by the fune	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe		, factory, office		28f. Location (S City or Tox		er or Rura	al Route Number,
To the Hospital or Attending Physician 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 12 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner steted.	nowledge, deeth or netion and/or inves	ocurred at the t tigetion, in my	ime, dete end place, opinion, death occur	end due to the red et the time,	cause(s) and ma date and place,	nner as s and due to	itated. the cause(s)
Within To the composition	29b. Signature and tible of certifier				se number		29d. Date signe		
ON'	1//	ND		DY	144)		Januar-	17	2000
U,	30. Name and address of person who of	ompleted cause of death (It	em 23a) (Type, Pri	nt)	7447 e Lane	Cal	Januar- Rusuil	144	
	31. Date filed (Month, Day, Year)	32. Registrer's Sig		CVU	7	61	1 () -(100	WC	70

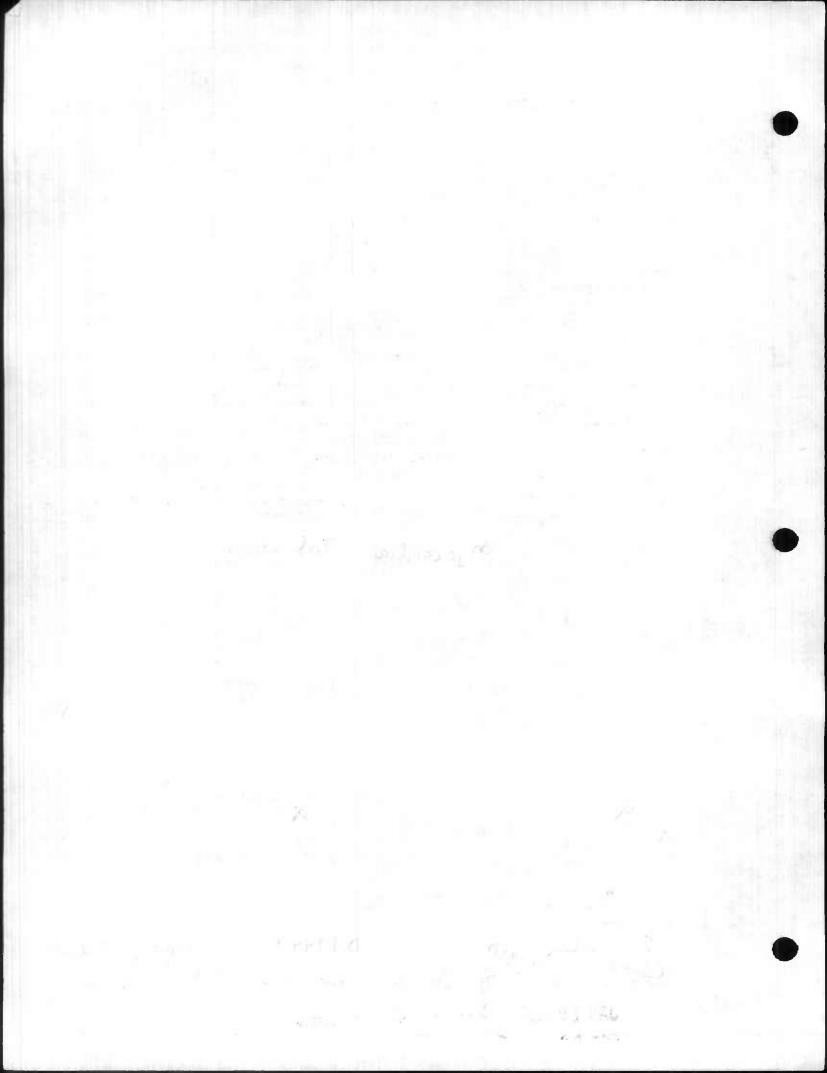
State Registrar

DHMH 16 Rev 6/95

JAN 19 2000

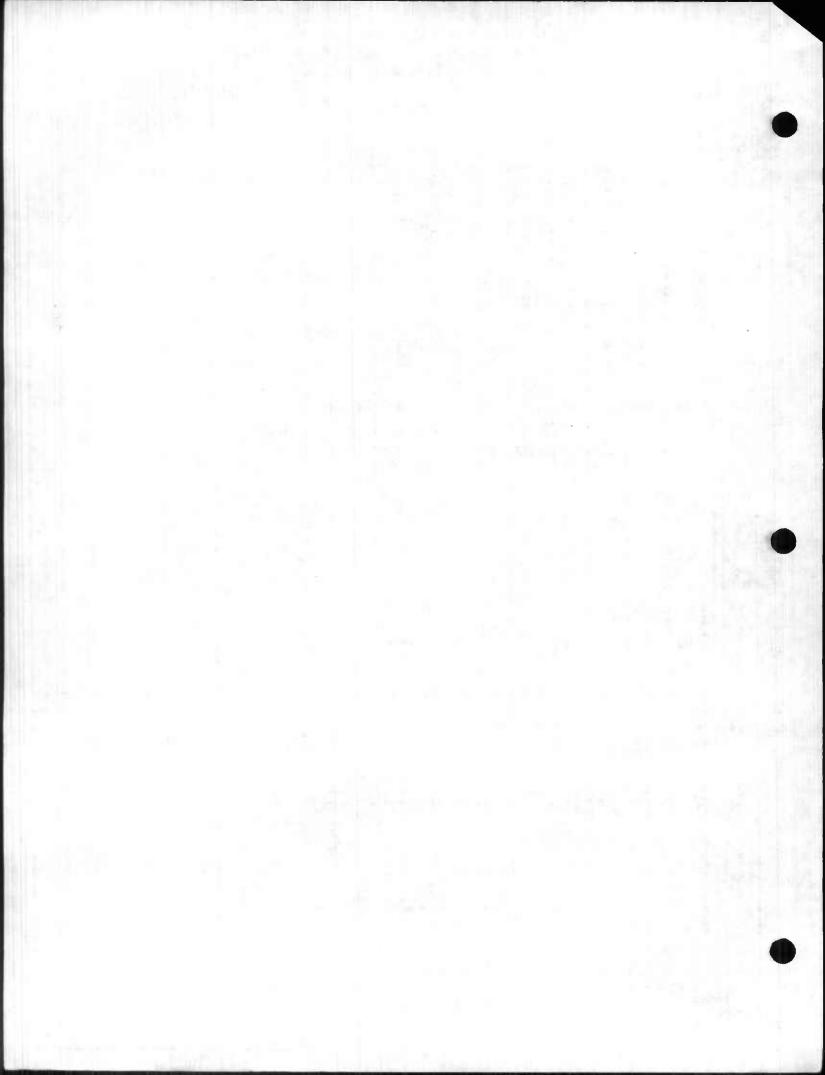
32. Registrer's Signetul

B. Sparts



	1. Decedent's Na	me (First, Middle, La	st)					2. Date of Dea		Vana	3. Time of Deat
an al	DARI	LENE		DOCKI	NS			Month JANUARY	Day 15,20	Year 00	8:12P.M
	4a Facility Name	(If not institution, given	re street end num	ber)			4b. City, Town, or L	ocation of Death			
The second second		OUR HOSPIT					BALTIMOR			N/A	
	5. Social Security	1260	Sex I□M 2CXF	7. Age (In yrs. I 42		Months Days		8. Date of Birth (Month, Day NOV . 1,		9. Birthpla Country MD	ice (State or Fore y)
- 1-	Usual Residence 10a. State	10b. County		10c. City	, Town or L	ocation				100	d. Inside City Lin
DI GOIG	MD	N.	/A		BALTI	MORE					1□Yes 2□ XX
	10e. Street and N					10f. Zip Code			10g. Citizen of V	What Countr	
Funeral						212	17			USA	
		rried 2 Married	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 X No	S. 13.	Was Decedent of if Yes, specify Cu 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - Americai ck, White, et /: BLA	tc.
L		15. Decedent's E	ducation		16a. Dece	edent's Usual Occi	upation		16b. Kind of Bu	usiness/Indu	ıstry
-	(Specification)	condary (0-12)	de completed) College (1-	4or 5+)			e during most of work red)	unig			
De Completed					REC	EPTIONIS		/E:	HUMAN R		ONS
1	17. Father's Name (First, Middle, Last) OZ DOCKINS						18. Mother's Nam	DODD	Meiden Surnam	10)	
2					10h 11cm	ing Address (Cu-	et end Number or Rus		City or Tour	State 7in /	Code i
		Name/Relationship									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
-	20a. Method of Di	DOCKINS	MOTHER		ace of Disp	3 W. NOR osition (Name of		BALTO.,	MD. 212 20c. Location -		m, State
		2 ☐ Cremation 3 ☐ 5 ☐ Other (Speci		tate		N CEM.		1/22/200	O BALTO	MD	
		Funeral Service Lice					MORTON &				
	1	2ma-	a.Wl	oten			RENS ST. I				
+	23a. Paul Enter	the disease, or con	plications that c	used the death			ying, such as cardiac				Approximate
1	shock, or he	eart failure. List only	one cause on e	ich line.							interval Between Onset and Death
	immediate Cause disease or condit	e (Final	ME.	THADONE	INTO	XICATION				1	
ŀ	resulting in death		a	Due to (o	r as a conse	equence of):		-			
-			Ь								
	Convention to the	conditions,	0	Due to (or	r as a conse	equence of):					
	if any leading to	derivina 🛲	c								
- 1	Sequentially list of any, leading to cause. Enter Und Cause (Disease of			Due to (or	as a conse	quence of):					
- 1	cause. Enter Uni	nts									
	Cause (Disease of that initiated ever	nts	d							1	
	cause, Enter Un Cause (Disease of that initiated ever resulting in death	ots) Last	d					non plat			ah a aassaa ad da
	cause, Enter Un Cause (Disease of that initiated ever resulting in death	nts	d	ath but not resu	ulting in the	underlying cause (given in Part i.				the cause of de
	cause, Enter Un Cause (Disease of that initiated ever resulting in death	ots) Last	dcontributing to de	ath but not resu	ulting in the	underlying cause (given in Part i.		obacco uae co Yes 2 No	ntribute to	. /
	cause, Enter Un Cause (Disease of that initiated ever resulting in death	ots) Last	d	ath but not resu	ulting in the	underlying cause (given in Part i.	1 □ 1	Yes 2□ No an autopsy	3 Probe	ably 4 Unk
	cause, Enter Un Cause (Disease of that initiated ever resulting in death) Last	dcontributing to de	ath but not resu	ulting in the	underlying cause (given in Part i.	1 □ 1	Y## 2□ No	3 Probe	ably 45 Onki
	cause, Enter Un Cause (Disease of that initiated ever resulting in death) Last	d	ath but not resu	ulting in the	underlying cause ç	given in Part i.	1 □ 1	Yes 2 No an autopsy med?	3 Probe	ra autopsy findin ilable prior to appletion of cause
	cause, Enter Un- Cause (Disease of that initiated ever resulting in death Part ii. Other eigr 25. Was case refi	its) Last ifficant conditions	d	ath but not resu	ulting in the	underlying cause (given in Part i.	1 24a. Was perfo	an autopsy med?	3 Probe	ra autopsy findinitiable prior to apletion of cause eath?
	cause, Enter Un- Cause, Disease of that initiated ever resulting in death Part ii. Other sign 25. Was case ref- examiner?	its) Last ifficant conditions	Hospitai		ulting in the		26. Place of Dea	1 24a. Was perfo	an autopsy med? /es 2 \sum No	24b. Wer avai	ra autopsy findingiable prior to apletion of cause eath?
	cause, Enter Un- Cause (Disease of that initiated ever resulting in death Part ii. Other eigr 25. Was case ref- examiner?	its) Last ifficant conditions of the condition	Hospital: 1 Ir	ipatient 250,	ER/Outpatie 28b. Time	ent 3 DOA C	26. Place of Dea Other: 4 □ Nursing H jury at lork?	24a. Was perfo	an autopsy med? /es 2 \sum No	24b. Wer avail common of distributions o	ra autopsy findingiable prior to apletion of cause eath?
	cause, Enter Uncause, Disease of that initiated ever resulting in death Part II. Other eigr 25. Was case reference of the examiner? 1 Yes 2[27. Manner of Death 1 Naturai 2 Accident	erred to medical No ath 5 Pending investigation	Hospital: 1 at 1 at 28a. Date of Monti	patient 253	ER/Outpatie 28b. Time Injury FOUND	ent 3 DOA Cor	26. Place of Dea Other: 4 □ Nursing H jury at ork? □ Yes 2 □ ∰0	24a. Was perfo	an autopsymmed? //es 2 \(\text{No} \) //es 2 \(\text{No} \) // No //ence 6 \(\text{Oth} \) OWN	3 Probe 24b. Wer avai corr of di 1 mer (Specify)	ably 4 unker ra autopsy findin ilable prior to apletion of cause eath? Yes 2 No
	cause, Enter University of the Cause (Disease of that initiated ever resulting in death Part II. Other eigr 25. Was case reference oxaminer? 1	erred to medical No ath 5 Pending investigatio 6 X Could not be	Hospital: 1 in 28a. Date of FOUNT 1 28e. Placa 28e. Pla	patient 25 finjury, Dey Year)	ER/Outpatie 28b. Time Injury FOUND	ent 3 DOA C	26. Place of Dea Other: 4 □ Nursing H jury at ork? □ Yes 2 □ ∰0	24a. Was perfo	an autopsymed? Yes 2 No	3 Probe 24b. Wer avai corr of di 1 mer (Specify)	ably 4 unker ra autopsy findin ilable prior to apletion of cause eath? Yes 2 No
	cause, Enter Uncause (Disease of that initiated ever resulting in death Part II. Other eigr 25. Was case refexaminer? 1	erred to medical No ath 5 Pending investigatic 6 X Could not t determined	Hospital: 1 in FOUNI 28a. Date of Month FOUNI 28e. Place buildin	patient 25, finjury, bey Year) 1: 2000 1: 7007 1: 7007 2: 8000 1: 7007 1: 7000 1: 7000	ER/Outpatie 28b. Time FOUND Towns, farm, s	ent 3 DOA Confidence of P 28c. In 11 treet, factory, office	26. Place of Dea Other: 4 □ Nursing H jury at ork? □ Yes 2 □ No	24a. Was performent of the Check only of the Check on	an autopsymed? fes 2 No noe) dence 6 Oth now injury occur OWN Street and Numble Nor, Stete) 53 ORE, MD	3 Probe 24b. Wer avail corr of did 1	ably 4 Onker Ta autopsy findin Illable prior to apletion of cause eath? Yes 2 No
	cause, Enter Uncause, Enter Uncause (Disease of that initiated ever resulting in death Part II. Other eigr 25. Was case referaminer? 1 Yes 2[27. Manner of De. 1 Natural 2 Accident 3 Suicide	erred to medical No ath 5 Pending investigatic 6 (**Could not be determined**)	Hospital: 1 I in Province 1 28a. Date of Month FOUNT 28a. Place building a position of the balance of the balan	patient 25 finjury Dey Year) injury Hinjury Hinjury Gi Injury Gi C. (Specif) OUND Set of examinat	ER/Outpatie 28b. Time Injury FOUND A. Parth, so HOUSE Wiedge, dea	ent 3 DOA Cof P 28c. In W	26. Place of Dea Other: 4 □ Nursing H jury at ork? □ Yes 2 □ ∰0	24a. Was performent to the Check only of the Check only of the Come 5 Residue 1 UNKN 28f. Location (1 City or Tor BALTIM, and due to the	an autopsy med? fes 2 No one) dence 6 Oth now injury occur OWN Street and Number, State 33 ORE, MD cause(s) and ma	3 Probe 24b. Wer available common of did to the co	ably 4 unker ra autopsy findin rilable prior to rapletion of cause eath? Yes 2 No
	cause, Enter Uncause, Clisease of that initiated ever resulting in death Part II. Other eigr 25. Was case reference as a large of the examiner? 1 Yes 2 27. Manner of Declaration of the examiner? 1 Natural of the examiner? 29a. Certifier (Check only)	erred to medical No ath 5 Pending investigatic 6 [X Could not t determined]	Hospital: 1 I I I I I I I I I I I I I I I I I I	patient 25 finjury Dey Year) injury Hinjury Hinjury Gi Injury Gi C. (Specif) OUND Set of examinat	ER/Outpatie 28b. Time Injury FOUND A. Parth, so HOUSE Wiedge, dea	ent 3 DOA Control of P 28c. In W 11 treet, factory, office th occurred at the nvestigation, in my	26. Place of Dea Other: 4 Nursing H jury at ork? Yes 2 Nursing H etime, date and place	24a. Was performent to the (Check only come 5 Reside 28d. Describe 1 UNKN) 28f. Location (3 City or Towns and due to the time,	an autopsy med? fes 2 No one) dence 6 Oth now injury occur OWN Street and Number, State 33 ORE, MD cause(s) and ma	24b. Wer available common of discommon of di	ably 4 unker Ta autopsy findin Ilable prior to apletion of cause eath? Yes 2 No Pour Number, ated. the cause(s)
	cause, Enter Uncause (Disease of that initiated ever resulting in death Part II. Other eigr 25. Was case reference of the control of the co	erred to medical No ath 5 Pending investigatic 6 [X Could not t determined]	Hospital: 1 I in Province 1 28a. Date of Month FOUNT 28a. Place building a position of the balance of the balan	patient 25 finjury Dey Year) injury Hinjury Hinjury Gi Injury Gi C. (Specif) OUND Set of examinat	ER/Outpatie 28b. Time Injury FOUND A. Parth, so HOUSE Wiedge, dea	ent 3 DOA Cof P 28c. In W 11 treet, factory, officeth occurred at the envestigation, in my 29c. Lice	26. Place of Dea Other: 4 Nursing H jury at / Ork? Yes 2 Sto	24a. Was performent to the (Check only come 5 Reside 28d. Describe 1 UNKN) 28f. Location (3 City or Towns and due to the time,	an autopsymmed? fes 2 No	3 Probe 24b. Wer avai com of di 1 her (Specify) rred anner as sta and due to	ably 4 Unkr

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Deta of Death DANIEL DEMBER JANUARY 1 I Pey 2000 1250 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL BALTIMORE Birthplece (Stete or Foreign Country) NY If Under 24 Hrs. Hours Min. If Under 1 Yaar 8. Dete of Birth (Month, Dey, Year) Aug. 13, 1931 5. Social Security Number 7. Aga (In yrs. last birthday) M 2□ F Months Days 124-24-8530 68 Yrs. Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Md. Hanover 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 19 Blue Spruce Drive 17331 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indien, Black, White, atc. 1 Naver Merried Merried 1 ☐ Yas 2√ No If Yes, Give Yaar or Detes: Specify: Black 1 ☐ Yes 2XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) New York State Supervisor Mental Health 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Daniel Dember Delila Smith 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Delores E. Dember wife 19 Blue Spruce Drive Hanover, Pa. 17331 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Durial 2 Cremetion 3 Removel from Stete New Cathedral Cemetery Jan. 17 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21, Signeture of Funerei Service Licensee 22. Name and Address of Facility Nutter Funeral Homes, Inc. Then 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or hear failure. List only one cause on each line. Onset and Death Myocardial In Immediate Cause (Final Helms diseese or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or as e consequence of) lonsor ecus Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CABG Abdominal acotic 24b. Were eutopsy findings evaileble prior to completion of ceusa of deeth? 24a. Wes en autopsy 1 Yes 24 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ EA/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

DHMH 16 Bey 6/95

Division of Vital Records, P.O.

Dember

Daniel

State Registrar

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

with the Manyland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any litury or other traumatic event, its Medical Exercise, mail be notified at any injury or other traumatic event, its Medical Exercise, mail be notified at

Physician /Medical

Examiner

ed by the attending physician and detached for use as the burial-transit

been signed by the should be detach

Aftar this cartificeta

al or Attendin after death.

Hospital of To the Hospital within 24 hours a To the Funeral Complataly filled Examiner

cai

Physician/Medi

þ

Completed

Be

2

edicai

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Dey, Year)

Molamund Salcem

32. Registrer's Signeture

Soorka

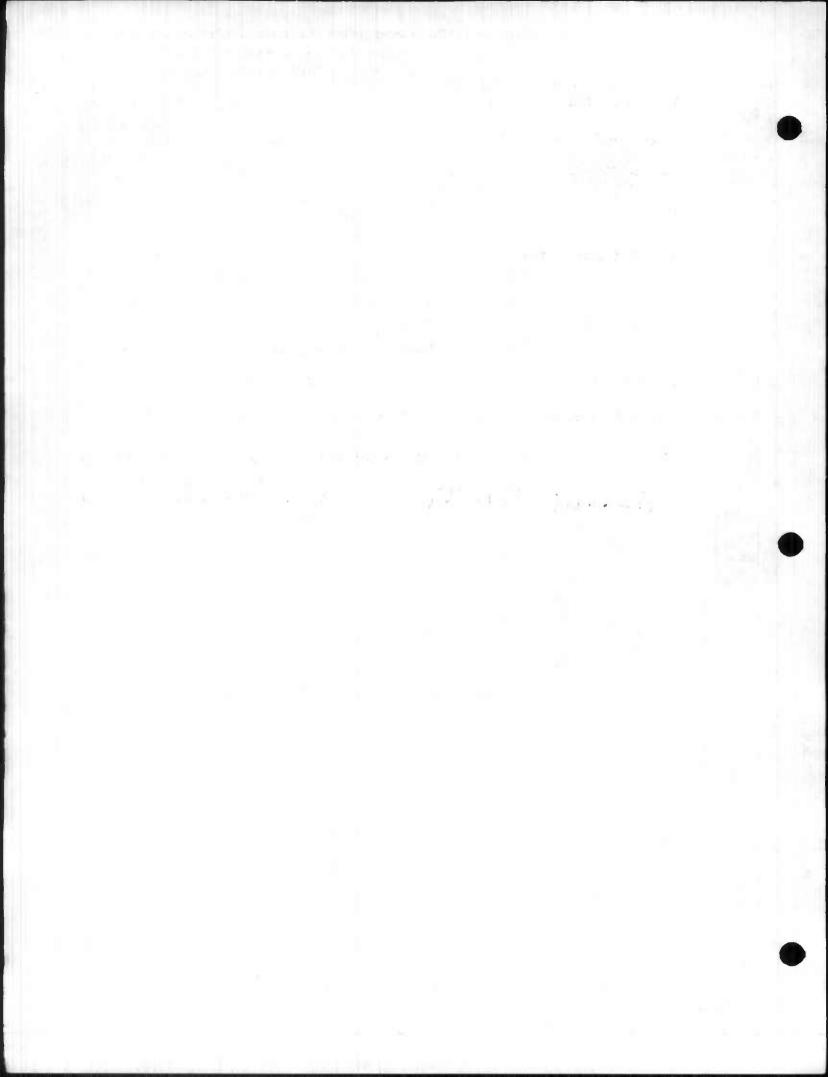
D40610

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAWMAD SALEEM, STAGNES HOSP, EMERGE

MOHAWMAD SALEEM, BALTIMORE, MD 21229 EMERGENCY ROOM

January 11, 2000

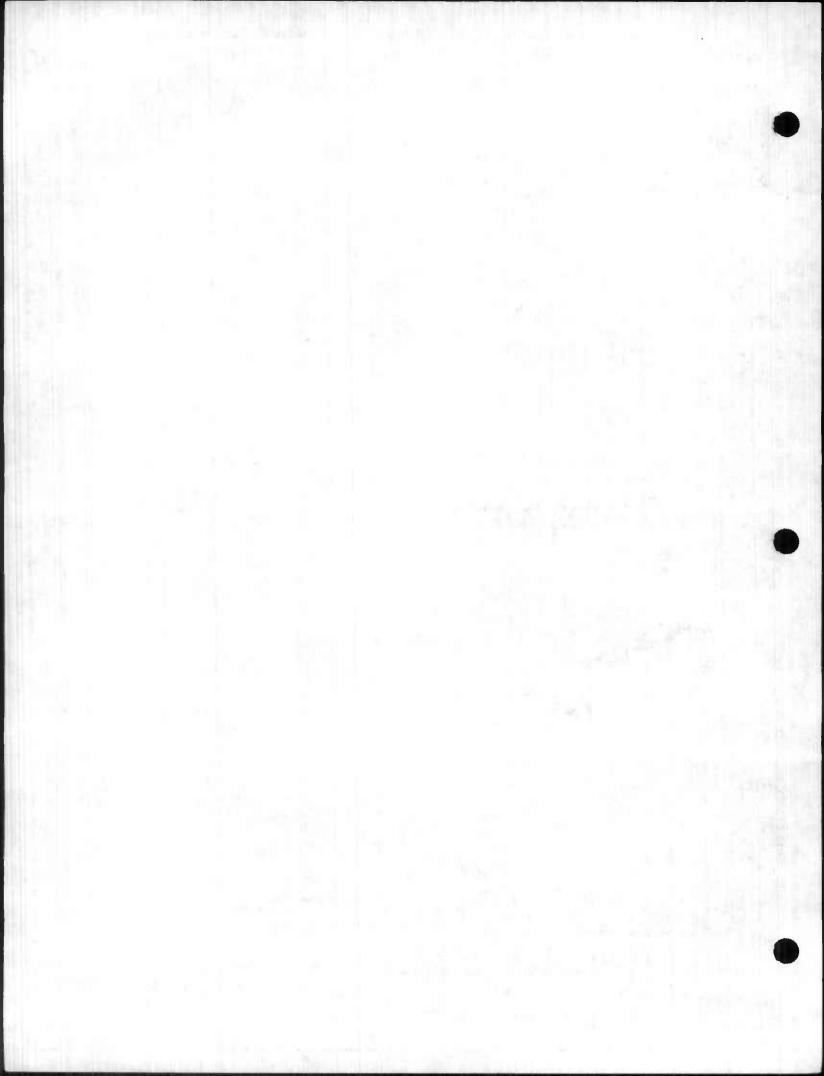


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

0	0	1	0	-	-
U	U	1	U	0	C

sician edical	EMS: #23 PART 1. Decedent's Name (First, Middle, L	ast)	ER MEO Louis Et	<u>Cértificate of</u>		2. Date of Dec Month JANUA	Day	Year 2000 1304
	4a Facility Name (If not institution, gr FRANKLIN SQUARE	ive street and number)			4b. City, Town, or Lo	ocation of Death	,	
	5. Social Security Number 6.		e (In yrs. lest birt	hdey) if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De) 9-20	h v. Year)	Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr					10d. Inside City Limits
8 8	Md N/A 10e. Street and Number 3506 Clifton Av	enue	Baltin	10f. Zip Code 21216	5		10g. Citizen of N	X1√Yes 2 No What Country?
	11. Marifal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 [Yes 2] 1 If Yes, Give Year or Dates:		13. Was Decedent of H ff Yes, specify Cubi	dispante Ortgin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	ee - American Indian, ck, White, etc. // Black
Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) 12th grade		5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire CCUrity Guar	during most of work d)	ing		usiness/industry Atlantic
To Be C	17. Father's Name (First, Middle, Las James Ebbs, Sr	()			18. Mother's Nam Susan W	halen		
	19a. Informant's Name/Relationship Edna Clark - Fri 20a. Method of Disposition		P 20b. Place of	Mailing Address (Street O. Box 107 Disposition (Name of	7 Upper F		21156	State, Zip Code) City or Town, State
	1 Donation 5 Other (Spec	ify)	cemeter	on Forest Ve	et 1			Mills, Md
	21. Signature of Funeral Service Lice	u) or or	2)	22. Name end Addre March F/H We 4300 Wab	est	e Ralt	imoro l	Md 21215
an al er aniner us	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last	b	Due to (or as a c	consequence of):	EROTIC	CARDIO	VASCUL	AR DISEASE
by Physician/Me	Part II. Other significant conditions	contributing to death b	ut not resulting Ir	the underlying cause given	ven in Part f.		tobacco usa co	ontributa to the causa of death?
Completed by P							an sutopsy med?	24b. Were sutopsy findings available prior to completion of cause of death?
Сотр	25. Was case referred to medical				OC Blass of Dass	1,20		1XYes 2□ No
5 B	examiner? 1 XYes 2 No	Hospital:		patient 3CXUUA		ome 5 Resid	dence 6 Oth	
cation	27. Manner of Death 1 Neturel 5 Pending Investigation 3 Suicide 6 Could not determine	be 200 Blace of Ini	y Year) li ury - At home, fa	ime of plury Mo 1	ry at rk?] Yes 2 □ No			ber or Rural Route Number,
Medical Certifi			examination and	deeth occurred at the tild For investigation, in my o				
edicai								

DHMH 16 Rev 6/95

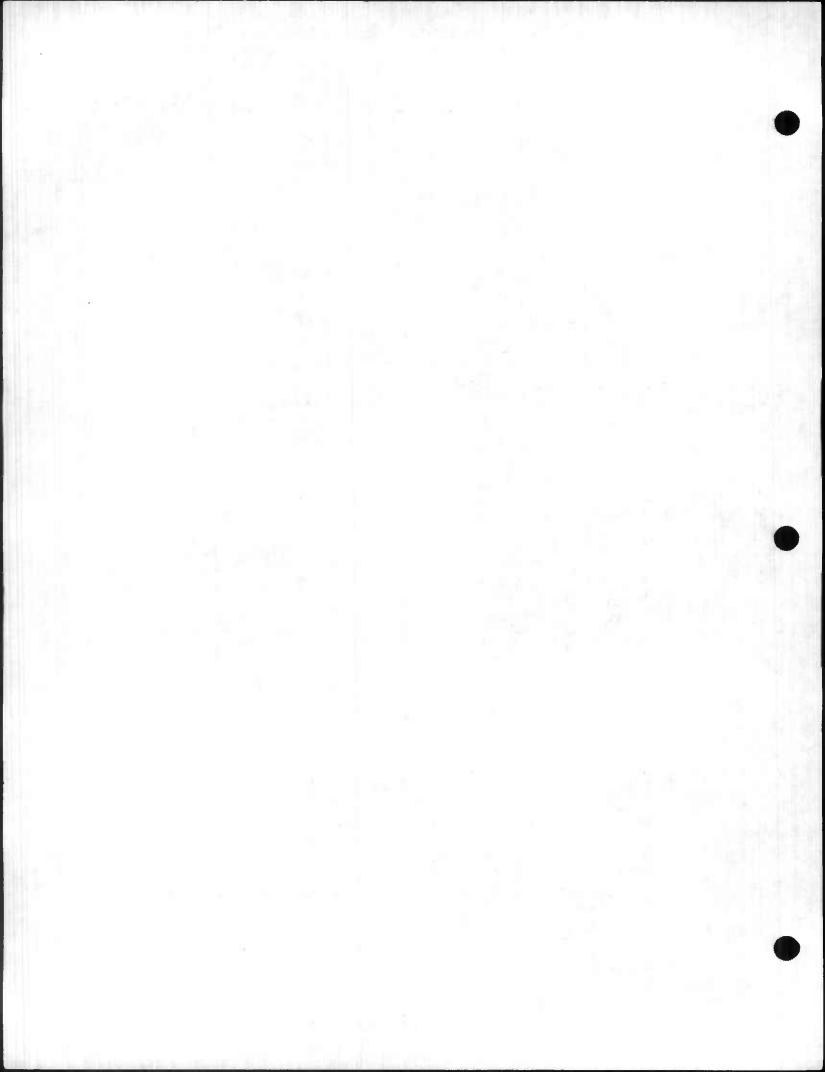


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

		State of Maryland / Department of Health a Certificate of Death		jiene ()	01069	
		1. Decedent's Nama (First, Middle, Last)	2. Date of Dea		3. Time of Deeth	
п	Physician	Frank Henry Ecker1	Month		Year 000 8:42 P.M.	
90	/Medical		January m, or Location of Death	4c. County of		-
	Examiner		imore		/A	
		•				
	Funeral Director	5. Social Security Number 6. Sex 1 Morths Days Hours 6. Sex 4 Pres. 4 4	Min. 8. Date of Birth (Month, Day) July 30		Birthplace (State or Foreign Country) Maryland	_
	De R.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	with the Marylan or 28a-f ahow be notified at Director	Maryland Anne Arundel Baltimore			1 ☐ Yes 2](No	
	or 28e-f a	10e. Street and Number 10f. Zip Code		0g. Citizen of W	hat Country?	
	10 M			U.S.		
	ath w	5401 Wasena Avenue 21225				
	ar dear Name: Der m.	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, , White, etc.	
2	4 29 E	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 □ Yes 2 No Specify:		Specify:	What ha	
21215-0020	E. E.	3 ☐ Widowed 4 ☐ Divorced Year or Datas:			White	
N.	72 h	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highast grada completed) (Give kind of work done during most	of working	16b. Kind of Bus		
2	an an ide	Flementery/Secondary (0-12) College (1-4or 5-) life. DO NOT use retired)			Security	
2	ed within 72 ho rgiene. er then "naturn it, the Medical Completed	12th Clerical			stration	
P	Be doth		's Name (First, Middle,)	
/la	Ment Alent Inches	(not available) Eckerl	Rose Mary	Heim		
Man	od 2 sho ith and 3 27 is me traums	19a. Informant's Name/Relationship (Type, Print) Mary Toolan / Sister 19b. Mailing Address (Street and Number 5319 Patrick Henry			State, Zip Code) 21225 , Maryland)
9	Hoa H	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - C	City or Town, State	
9	9 4 9	1 Buriar 2 DCremation 3 Linemoval from State	1/18/00	Towson	Maryland	
=	right .	4 Donation 5 Other (Specify) HIIICOP Service Corp. 21. Signum of Funeral Service Licensee 22. Name and Addrass of Facility				_
Ba	Maga Maga Maga Maga Maga Maga Maga Maga		GOILCE I		Home P.A.	
-		Ampan Francioushi 4001 Ritchie High			1d. 21225	
		231 Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as a shock, or haart failure. List any or a cause on each line.	cardiec or respiretory an	est,	Approximate Interval Between	
1	Physician				Onset and Death	
10	/Medical	Immediate Cause (Final disease or condition Aleute Hull) Candial In	faretier		apute	
н	Examiner	resulting in death) Bue to (or es a consequence of):	2			_
	je je	Atherocaleratio Keent	Or clave	,	5-6 year	4
	be executed iclan and burial-transit	Sequentially list conditions. Due to (or es a consequence of):				
ó	be exe iclan au burial-i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	a orbling		5-6 year	4
760	8 C 0 O	that initiated events Due to (or as a consequence of):	1-1-1			_
68	The law requires that the death certificat tie has been signed by the attending phypage 2 should be detached for use as the Completed by Physician/Medi	resulting in death) Last	0			
Box	ndin Use	d				-
m	atte i for		000 0144		tribute to the cause of death	
0	at the death certifical by the attending phetached for use as the tached for use as the physician/Med	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	230. Did to	_		
0.	that deta	- Unionee of frethe King /h law	0 10	es 2 No	3 Probably 4 Unknow	m
Records,	The law requires the sate has been signed page 2 should be de Completed by P	0 6: 01	240 18/00	n autonou	24b. Were autopsy findings	-
0	been should	- Chropd Stendie	24a. Was a	med?	available prior to complation of causa	
ec	e law has b pe 2 s mple				of death?	
H		- Ald Chebro vaenler accident	1 🗆 Y	es 20No	1 □ Yes 2 No	
Vital	Physician: The rhis certificate ral director, peg	25. Was case referred a medical examiner?	of Death (Check only or	ne)		
f V	5 6 5 Y		rsing Home 5 Resid	ence 6 Othe	or (Specify)	
Jou	erth seral	27. Menne Deeth 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe h	ow injury occurre	ad	
0	ath. Fr. Ath e fur e fur	1 ☐ Natural 5 ☐ Pending (Month, Day Year) tnjury Work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ P	No			
Division	to or Attending P is after death. In Director: After the led in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		er or Rural Route Number,	-
Ö	affer din din	4 Homicide building, etc. (Specify)	City of Tow	71, Siale)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deet and manner stated				
	We Me	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed	I (Month, Day, Year)	
	PAT S	200. Englished and thing of certainer	15	C. Daid signed	100	
		Solvaer V- Kanneaus 000389	12	01/1	100	
	0	30. Name and address of person who completed cause of death (Item 23s) (Type, Print) SALVAGO	N D. RA	MIRE	Z 4-D.	
	2	1720Crain Highway Sinke 204 GlenBurne	nen	21061		
	State	31. Date filed (Month, Dey, Year) (32. Registrar's Signature				

DHMH 16 Rev 6/95

ORIGINAL

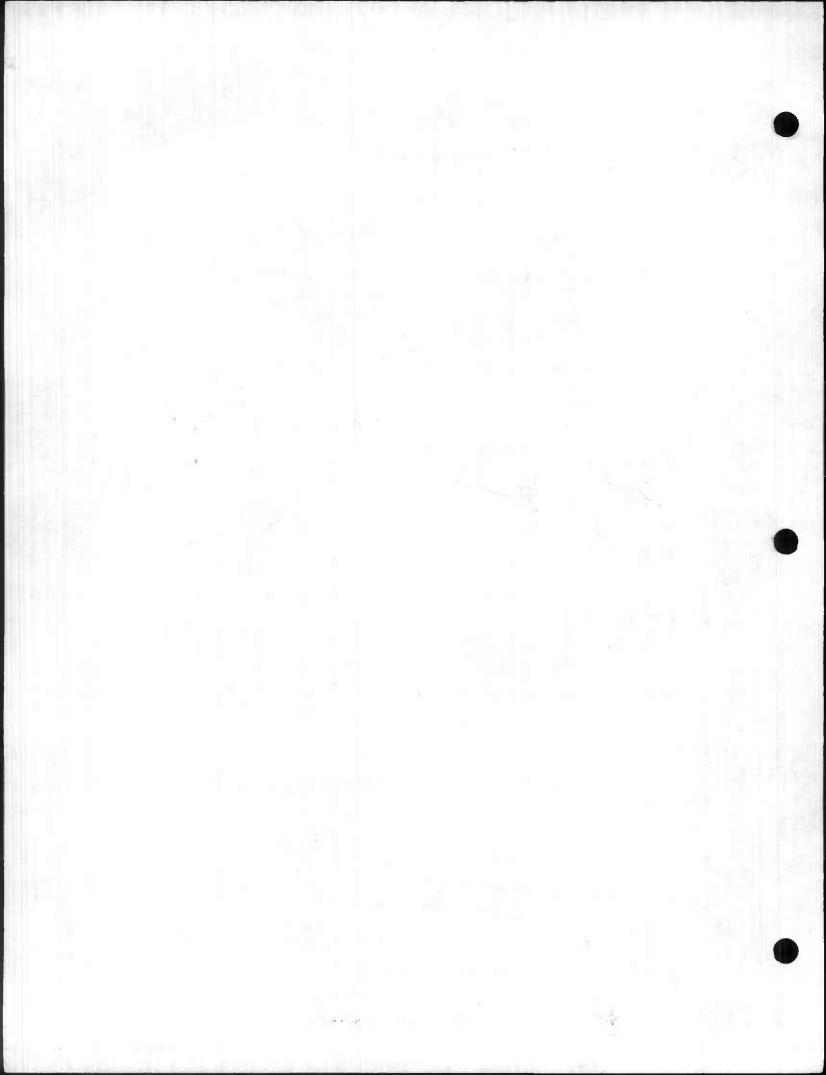


Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legibie.
State of Maryland / Department of Health and Mental Hygiene

					Cen	ilicate of	Death		Reg. No.	01010
	1. Decedent's Na	me (First, Middle, L			_			2. Date of De Month	eath Day	3. Time of Death
Physician /Medical			Josephi	ne A.	FCO	Iono		JANUA		000 01:08 A.
Examiner	4a Facility Name	(If not institution, gi	ve street and number				4b. City, Town, o	or Location of Deat	h 4c. County	
			RE MEDICAL			W11 4 4 14	TOWSON			TIMORE
uneral	5. Social Security		Sex 7. A 1 □ M 2 🗹 F	ge (In yrs. last 67	t birthday) Yrs.	Months Days		n. (Month, Da	rth ay, Year)	Birthplace (State or Fore Country)
irector	218-28-8 Usual Residence		1	0/	113.			8/13/193	52	Baltimore Md.
8 m	10a. State	10b. County		10c. City, T	own or Loc	ation				10d. Inside City Lim
rector	Md.	Baltimore	9	Balt	imore					1 ☐ Yes 2 🛣
or 28a-f	10e. Street and N	umber				10f. Zip Code			10g. Citizen of V	What Country?
23a o	6814 Pa	arsons Ave.				21207			LICA	
r Name 23a or 25a-f a biner must be notified Funeral Director	11. Marital Status		12. Was Decedent	Ever in U,S.	13. W	13. Was Decedent of Hispanic Origin? (S		(Specify Yes or No		a - American Indian,
or he	1 Never Ma	rried 2 Married	Armed Forces				ban, Mexican, Pu	erto Rican, etc.)		ck, White, etc.
5 6	3)CXWidowed	4 ☐ Divorced	If Yes, Give Year or Dates:		11	☐ Yes 2 💢 No	Specify:		Specify	" White
avent, me medical Englishment, medical Englishment Be Completed by	/0=	15. Decedent's E		1	6a. Decede	ent's Usual Occu	pation	adia	16b. Kind of Br	usiness/Industry
	Elementary/Sec	ecify only highest gr condary (0-12)	College (1-4or	5+)			during most of w	rorking		
# 4	12				Home M	laker			Own I	Home
vent Se	17. Father's Name	e (First, Middle, Las)				18. Mother's N	ame (First, Middle	, Maiden Suman	ne)
aumatic avent, the To Be Comp	Canlo Taomina 19a. Informant's Name/Relationship (Type, Print)						Anr	na Matrano	ia.	
7 is marked other than traumatic avent, the M To Be Comp					19b. Mailing	Address (Stree		Rural Routa Numb		Stata, Zip Code)
	Frances Ha	arris-Sister	•		53 Bur	kleigh Ro	. Towson,	Md. 21286		
r other	20a. Method of Di			20b. Place	e of Dispos	ition (Nama of		Date	20c. Location -	City or Town, State
Important: If Nem 2 eny Injury or other once.		2 ☐ Cremation 3 L 5 ☐ Other (Speci	Removal from State (fy)			est Cemet	,	1/19/2000	Ouings N	Wille Md
and and		Service Lice	4	Tour 11.		Name and Addr	ner of Escitibe		-	,
Fed	D IIII	MILLIA S	+11/1-			EOUE Have	ord Rd. Mo		Kuck Funer	ral Home Inc.
	23a. Part1. Enter	the dispass, or con	nplications that cause one cause on each l	d the death. [errest.	Approximate
sician	shock, or he	eart fall List only	one cause on each I	ne.						Approximate Interval Between Onset and Death
tical	Immediate Cause	(Finat	1004	1001C	0	2.1.7				1-115
niner	disease or conditi resulting in death	ion)	. 15CF							111/1
			ACU	Due to (or es		ence of):				244
the buriel-transit			b. // 00	Due to (or as						
EX8	Sequentially list of if any, leading to cause. Enter Und	immediate		Doe to for as	a consequ	once on.				
edical	that initiated even	or injury	c	Due to (or es	e conseque	ance of).				
_ = 0	resulting in death) Last		200 10 (0. 63	o consequ	onod ony.				
for use			d							
Physician/	Part II. Other sign	ificant conditions	contributing to death t	ut not resultin	or in the unc	Seriving cause o	iven in Part I	23b. Did	tobacco uss co	ntributs to the causs of dear
detached / Physic		EBSIS				, , , , , , , , , , , , , , , , , , ,			Yes 200	3 Probably 4 Unknown
								_	7-110	
200		00713								
à à		C0>13						24a. Was	an autopsy	24b. Were autopsy finding
2 2		(0)/13					100	24a. Was	an autopsy ormed?	svailable prior to completion of cause
has been signed to 2 should be d		Costa			4		1.81	perf	ormed?	svailable prior to completion of cause of death?
pege 2 should be d						7-4		perf	Yes 2 No	svailable prior to completion of cause
certificate has been signed riector, page 2 should be director.	25. Was case refe	erred to medical	Hospital:			27.20.10	ther	perfi	Yes 2 No	svailable prior to completion of cause of death? 1 Yes 2 No
his certificate has been signed all director, page 2 should be d	25. Was case reference examiner?	erred to medical	1 Estinpati		/Outpatient	3LI DOA	ther: 4 Nursing	perfine the perfin	Yes 2 No one) idence 6 □Oth	svailable prior to completion of cause of death? 1 Yes 2 No
frer this certificate has been signed moral director, page 2 should be don: To Be Completed by	25. Was case refe examiner? 1 ☐ Yes 2b 27. Manner of Dec 1 ØNatural	erred to medical No ath 5 Pending	28a. Date of Inju		/Outpatient lb. Time of Injury	28c. Inju	ther: 4 Nursing ary at ork?	perfine the perfin	Yes 2 No	svailable prior to completion of cause of death? 1 Yes 2 No
meral director, pege 2 should be don: To Be Completed by	25. Was case reference oxaminer? 1 Yes 25 27. Manner of Dec	erred to medical PNo ath 5 Pending investigatio 6 Could not be	28a. Date of Injury	iry iy Year) 28	b. Time of Injury	28c. tnji W	ther: 4 Nursing ury at ork? Yes 2 No	perfi	Yes 2 No one) idence 6 Oth how injury occur	svailable prior to completion of cause of death? 1 Yes 2 No ner (Specify)
frer this certificate has been signed meral director, page 2 should be don: To Be Completed by	25. Was case reference of the saminer? 1 Yes 25. 27. Menner of Dec. 1 Shatural 2 Accident	erred to medical PNo ath 5 Pending investigatio 6 Could not be	28a. Oate of Injure	iry iy Year) 28	b. Time of Injury	28c. tnji W	ther: 4 Nursing ury at ork? Yes 2 No	perfine the perfin	Yes 2 No one) idence 6 Oth how injury occur	svailable prior to completion of cause of death? 1 Yes 2 No
fer this certificate has been signed moral director, page 2 should be don: To Be Completed by	25. Was case referenced to the examiner? 1 Yes 2 S 27. Manner of Det 1 Matural 2 Accident 3 Suicide 4 Homicide	erred to medical No ath 5 Pending investigatio 6 Could not be determined	28a. Date of Inj (Month, Di	iry y Year) 28 jury - At home c. (Specify)	b. Time of Injury	28c. Inju W M 1[et, factory, office	ther: 4 Nursing ury at ork? Yes 2 No	perfine the perfin	Yes 2 No one) idence 6 Oth how injury occur (Street and Numb	svailable prior to completion of cause of death? 1 Yes 2 No No (Specify) red per or Rural Route Number,
trer this certificate has been signed moral director, page 2 should be don: To Be Completed by	25. Was case reference oxamine? 1 Yes 25. 27. Manufural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only)	erred to medical PNo ath 5 Pending investigation 6 Could not be determined	28a. Date of Inj. (Month, Date	iny Year) 28 iuny - At home c. (Specify) of my knowled examination	b. Time of Injury	28c. Inj W M 1E et, factory, office	ther: 4 Nursing ary at ork? Yes 2 No	perfi	Yes 2 No one) idence 6 Oth how injury occur (Street and Numbur, Stata)	svailable prior to completion of cause of death? 1 Yes 2 No No (Specify) red per or Rural Route Number,
the this certificate has been signed in a factor, page 2 should be don: To Be Completed by	25. Was case reference examiner? 1 Yes 25 27. Manner of Dec 1 SNatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier	erred to medical No ath 5 Pending investigatio 6 Could not to determined 1 Certifying Pt 2 Medical Exact	28a. Date of Init (Month, Di 28e. Place of In- building, el	iny Year) 28 iuny - At home c. (Specify) of my knowled examination	b. Time of Injury	M 28c. Inju W 1[et, factory, office coccurred at the lestigation, in my	ther: 4 Nursing ary at ork? Yes 2 No	perfi	Yes 2 No one) idence 6 Oth how injury occur (Street and Numb wn, Stata) cause(s) and me date and place,	svailable prior to completion of cause of death? 1 Yes 2 No No rer (Specify) red per or Rural Route Number,
neral director, pege 2 should be d on: To Be Completed by	25. Was case reference of the saminer? 1 Yes 25 27. Manner of Deat 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	erred to medical No ath 5 Pending investigatio 6 Could not to determined 1 Certifying Pt 2 Medical Exact	28a. Date of Inj. (Month, Date	iny Year) 28 iuny - At home c. (Specify) of my knowled examination	b. Time of Injury	28c. Injunction of the state of	ther: 4 Nursing ury at ork? Yes 2 No nima, data and pla opinion, death oc use number	perfilement (Check only) Home 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur (Street and Numb wn, Stata) cause(s) and me date and place,	svailable prior to completion of cause of death? 1 Yes 2 No No er (Specify) red per or Rural Route Number, anner as stated, and dua to the cause(s)
neral director, pege 2 should be d on: To Be Completed by	25. Was case reference oxamine? 1 Yes 25 27. Mantural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature an	arred to medical No ath 5 Pending investigatio 6 Could not be determined 1 Certifying Pt 2 Medical Exact dittle of certifier	28a. Date of Inj. (Month, Date	iny Year) 28 y Year) 28 jury - At home c. (Specify) of my knowled f examination ated.	b. Time of Injury o, farm, street dge, death of and/or inves	28c. Inju M 1E et, factory, office excourred at the 1 estigation, in my 29c. Licer	ther: 4 Nursing ury at ork? Yes 2 No ima, data and pla opinion, death oc	perfilement (Check only) Home 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur (Street and Numb wn, Stata) cause(s) and me date and place,	svailable prior to completion of cause of death? 1 Yes 2 No No er (Specify) red per or Rural Route Number, anner as stated, and dua to the cause(s)
fer this certificate has been signed moral director, page 2 should be don: To Be Completed by	25. Was case reference oxamine? 1 Yes 25 27. Mantural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature an	arred to medical No ath 5 Pending investigatio 6 Could not be determined 1 Certifying Pt 2 Medical Exact dittle of certifier	28a. Date of Inj. (Month, Date	iny Year) 28 iury - At home c. (Specify) of my knowled f examination ated.	b. Time of Injury o, farm, streed dge, death of and/or invention (Type, P	28c. Inju M 1E et, factory, office excourred at the 1 estigation, in my 29c. Licer	ther: 4 Nursing bry at ork? Yes 2 No ima, data and pla opinion, death oc ise number	perfit 1	Yes 22 No one) idence 6 Oth how injury occur (Street and Numb wn, Stata) cause(s) and ma date and place,	svailable prior to completion of cause of death? 1 Yes 2 No No er (Specify) red per or Rural Route Number, anner as stated, and dua to the cause(s)
tor: After this certificate has been signed the funeral director, page 2 should be director. To Be Completed by	25. Was case reference oxamine? 1 Yes 25 27. Mantural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature an	Private to medical Private and the private stigation of the could not be determined. 15 Certifying Private and title of certifier Could not be determined. 15 Certifying Private and title of certifier. Could not be determined. 16 Certifier and title of certifier. Could not be determined.	28a. Date of Initial (Month, Date of Initial (Month, Date of Initial (Month, Date of Initial I	iny Year) 28 y Year) 28 jury - At home c. (Specify) of my knowled f examination ated.	ib. Time of Injury a, farm, street dige, death and/or inve	28c. Inju M 1E et, factory, office excourred at the 1 estigation, in my 29c. Licer	ther: 4 Nursing bry at ork? Yes 2 No ima, data and pla opinion, death oc ise number	perfilement (Check only) Home 5 Res 28d. Describe 28f. Location (City or To	Yes 22 No one) idence 6 Oth how injury occur (Street and Numb wn, Stata) cause(s) and ma date and place,	svailable prior to completion of cause of death? 1 Yes 2 No No er (Specify) red per or Rural Route Number, anner as stated, and dua to the cause(s)

DHMH 16 Rev 6/95

14.5



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month 18, 2000 Year Alvina C. Frantz 3 P.M. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Milford Manor Nursing Home Pikesville Baltimore 8. Data of Birth Month, Day, Year Time 4, 1904 Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number Birthplace (State or Foreign Country) Days Months Hours 1 M 2 XF 213-34-4947 Yrs. Maryland Usual Rasidence of Dacedant 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Baltimore Pikesville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 741 Silver Creek Road 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. I ☐ Yas 2 📜 No If Yas, Giva 1 Nevar Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Vear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Housewife 17 Fathar's Nama (First Middle Last) 18 Mother's Name (First Middle Maiden Sumama) Herman Schulze Lena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian Tarbutton - Daughter 741 Silver Creek Rd., Pikesville, Md. 21208 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata Cedarhill Cemetery Jan. 20,2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licenti 22. Nama and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills. Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarvat Between Onset and Death eriosclopsus Immediata Causa (Final 20 years disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Tyes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicida

Box 68760. P.O. Division of Vital Records,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Physician

/Medical

Examiner

Funeral

Director

show

res 23a or 28a-f s r must be notified

or Reme

Pages 1 and 2 should be Illed within 72 hours ahar and of Hally and Mental Hybjans.

Intit Rem 27 is marked other than "netural, or the lay or other traumatic event, the Medical Examines into or other traumatic event, the Medical Examines.

Department of Important: If any injury or page.

Physician

/Medical

Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

edicai

21215-0020

Baltimore, Maryland

Director

Funeral

þ

Completed

Be

State Registrar 29b. Signatura and titla of certifian

29c. License number D0020964

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 01-19-00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and addrass of person who completed cause of death (tern 23a) (Type, Print)

8630 Liberty Plaza Mall Randallstown, MD Jerome H, Ginsberg, M.D.

31. Data filed (Month, Day, Year)

4 Homicide

29a. Certifier (Check only one)

JAN 1 9 2000

32. Registrar's Signature

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

title in the -- -- -- --effice 9% condition . The sills 0 The Commence of the State of th In the state of th cleret 3m del de velo.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Morkh **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number NURSING (IN 7. Age (In yrs) last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 250F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Items 23s Funeral 12 Was Decedent Evar in U.S. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or Nem any Injury or other traumatic event, the Mental of the Mental of New Mental of New Mental or other traumatic event, the Mental of New 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NORO4hi SIRSO 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

1 Disputal 2 Cremation 3 Removal from State Jan 20 20b. Place of Disposition (Name of I cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funéral Service License 22. Name and Address of Facility Evans Funeral Do not enter the mode of dying, such as dardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that causad the death, shock, or haart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yes ZONo 1 Yas 2 No Hospital or Attending Physician: 25. Was case referred to medical axaminer?

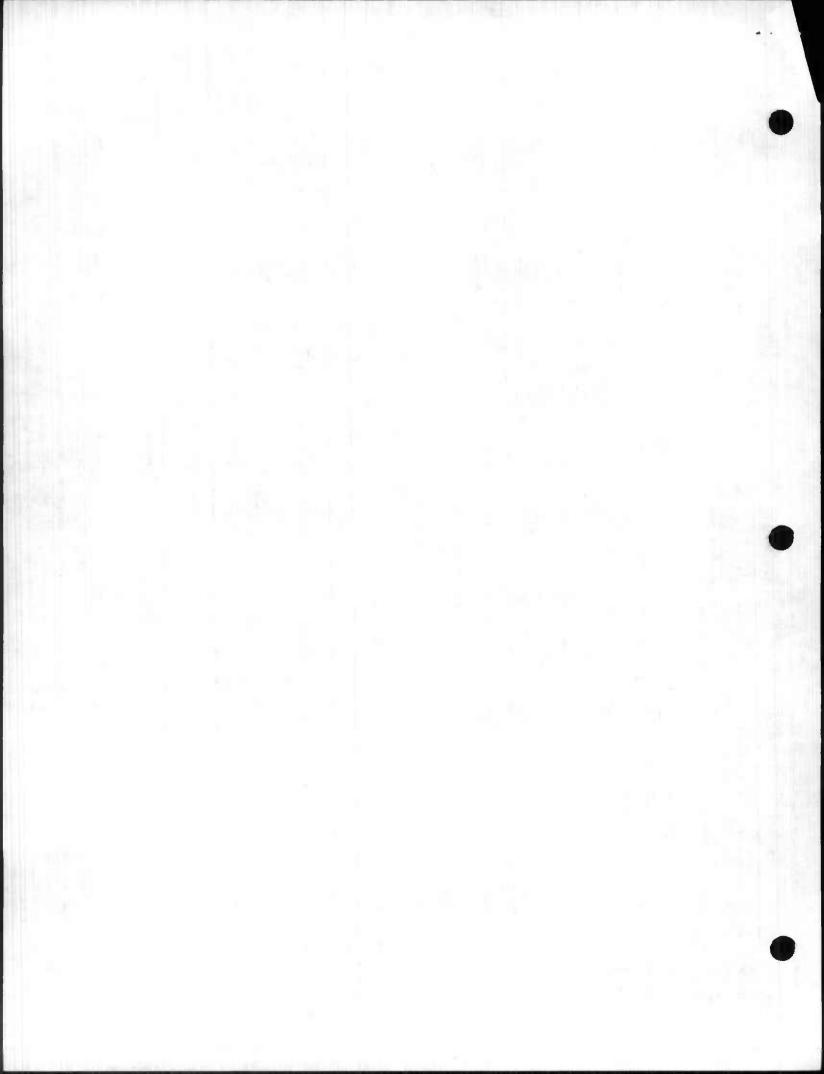
1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ŝ 29b. Signatura and titla ot certifier 29c. License number 29d. Date signed (Month, Day, Year) 154518 miramuna

DHMH 16 Rev 6/95

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

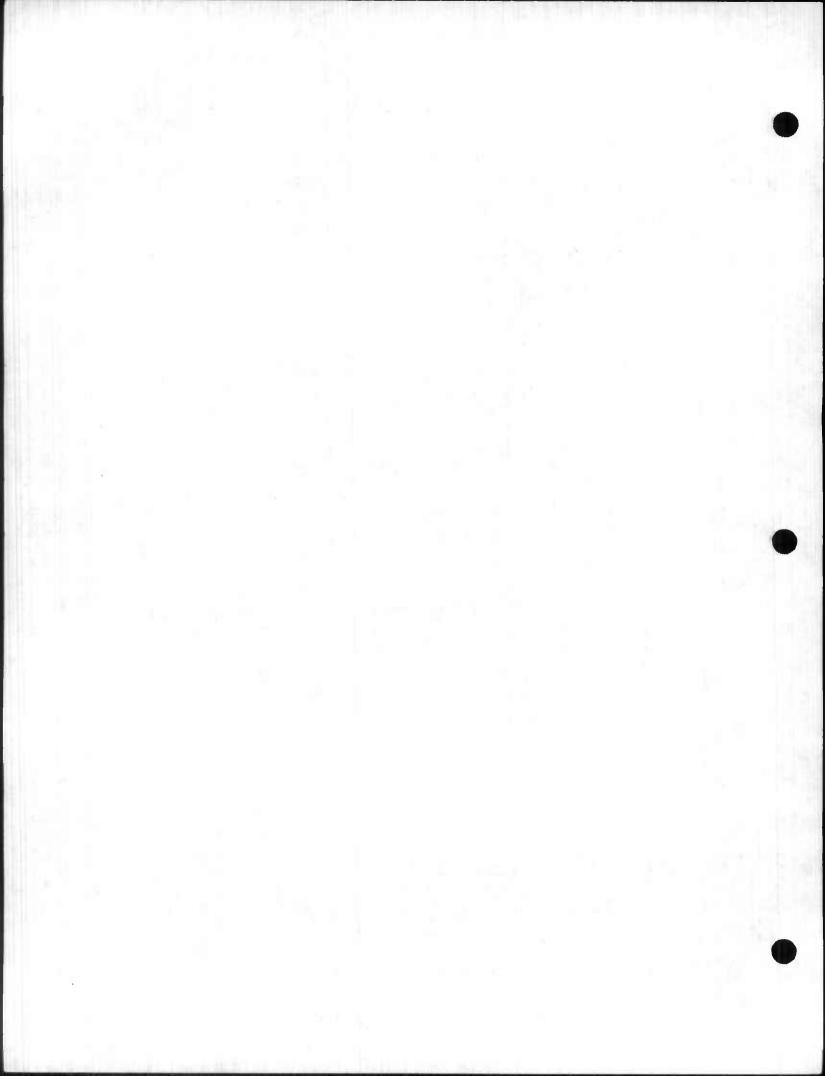
32. Regigifar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 0 7

					Cer	rtificate	e of	Death		Re	g. No.			
		1. Decedent's Name (First, Middle, Li						2. Date of Death				of Death		
Physici		Robert L. Fre				v Sr.			January	16 2	OOO	6:00	A.M.	
/Medic Examin	-	4a Facility Name (# not institution, git 59 Rol-Park Ti							ocation of Deeth	7				
Funeral Director			Sex 7. Age (In yrs. last birthdey) If Under 1 Months 1					If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Dec. 22,	Year) 1931		lace (State try) ryland	
y		Usual Residence of Decedent												
arytar ahow dat		10a. State 10b. County		10c. City, To								11	Od. Inside C	11-11-11
N P	cto	Maryland Anne Arundel Millersville											1 LI Yes	s 21K) No
ith with the Marylar 23s or 28s-f show ust, be notified at	al Directo	10e. Street and Number 59 Rol-Park Trailer Village 2110								10	g. Citizen of \U • S		try?	
lar dei ltama	by Funeral	11. Meritat Stetus 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 12 Yes 2 1 H Yes, Give Year or Dates:			. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric			ecify Yea or No- Rican, etc.)			- American Indian, k, White, etc. White		
5-0 72 ho natur	pet	15. Decedent's E		16	a. Deced	dent's Usua	Occup	ation	t of work	ina 1	6b. Kind of B	usiness/Inc	Justry	
within and the Man	Completed	(Specify only highest gr Elementary/Secondary (0-12) 11th	College (1-4or 5	i+)	(Give kind of work done during most of life. DO NOT use retired) Truck Driver			i or work	y	Truc	king			
Hygin Hygin	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam			ma (First, Middla, Maiden Sumame)						
ylar oud be Menta erkad erkad	To B		Carl Otto H	rey					Ka	therine	L. Tra	vers		
and N	-	19a. Informant's Name/Raiationship	Type, Print)	19	9b. Maitir	ng Address	(Street	and Numbe	er or Rui	al Route Number,	City or Town,	State, Zip	Code)	
C 72 FM No.		Sylvia Frey /	Wife	5	59 R	ol-Par	rk T	raile	r Vi	illage M	illers	ville	e, Md.	. 2110
Ore or off or off		20a. Method of Disposition 1 ☐ Burlat 2 ☑Cremation 3 [ceme	tery, cren	Disposition (Name of v, crematory or other place)			1		20c. Location - City or Town, State Towson, Maryland			
altim mit. Pag partment contant: r injury c		4 Donation 5 Other (Special		HILLT	illtop Servic				-					
Depa limpo		21. Signature of Funeral Service Lice	nsee			2. Name and			-	Gonce Fu				
box 68/60, death certificate be secuted e attending physician and ad for use as the burial-transit union	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events rasulting in death) Last	b	Due to (or as a	a consaq	quenca of):					736			
Both cert attendin	clan													
that the de detached	Physician/	Part ti. Other significant conditions	contributing to death be	ut not resulting	in the u	nderlying c	ause giv	en in Part	l.		a 2 No			of death? Unknown
ecords ew requires ss been sign s should be	Completed by									24a. Was an perform	autopsy ed?	CO	ara autopsy ailable prior mpletion of daath?	rto
The i	NO.									1 ☐ Yes	s 2 No	10	Yes 2	No
vitalican: T	Be	25. Was case referred to medical examiner?						26. Piace	ot Dea	h (Check only ons)			
Phy Phys	2	178 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Data of Inju (Month, Day		Outpatier Time of Injury	nt 3 DC	DOA Other: 4 Nursing Ho 28c. Injury et Work?		ome 5⊠ Residence 6 □Other (Specify) 28d. Describe how Injury occurred					
to: to:	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	tion M 1 Yes					Yes 2	No	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospita 14 hours Funeral tely fille	edical C	29a. Certifier (Check only one) Certifying Pl	nyatcian: To the best of miner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred a	at the ti	ma, data an opinion, das	d piace, ath occur	and dua to tha car red at the time, da	usa(s) and m ta and place,	anner as st	tated. tha cause	(s)
within 2 To the comple	M	29b. Signeture and title of certifier	and manner ste			290	. Licens	e number		29	d. Date signe	d (Month,	Day, Year)	
To vid		1 5/1							59					
7		30. Name end address of parson who			,			4	120	S. CRA	IN Hu	1. ; 5		3
1	4.0	31. Date filed (Month, Day, Year)		V IDA	4 VET	RIN	1.0	2, (5161	N BURN	EM	0 2	1061	1
° Sta Registr		JAN 1 9 2	000 54	A SIGNATURE	19	de	rous	2						

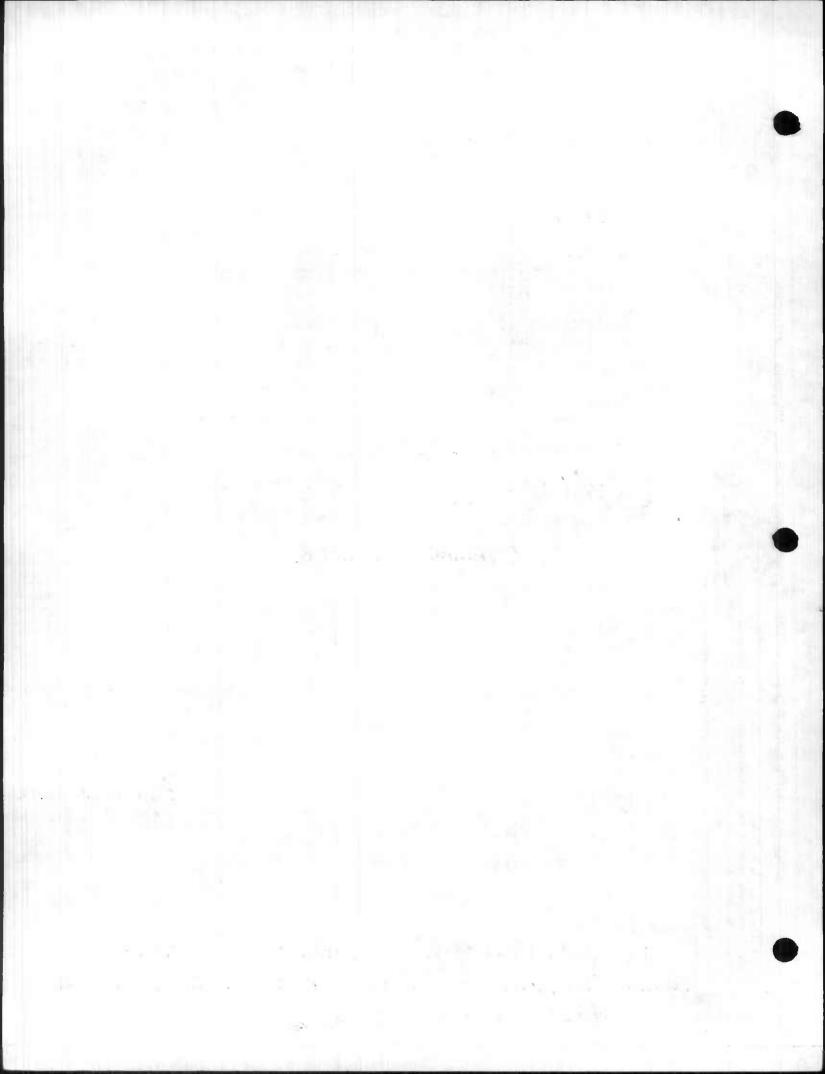


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Vaar **Physician** 11:15 P.H. Mary Louise Fitzpatrick JANUARY 14 2000 4c. County of Death /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Stella Maris Hospice - at Mercy Hospital **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 6, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□M 200 F 66 Yrs Director 034-24-7817 Massachusetts Usual Residence of Decedent he Marytand 10a State 10h County 10c. City, Town or Location 10d. Inside City Limita 1 Yes 2 No Director VA Prince William Woodbridge 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? B must be 2704 Harwich Court 22192-3706 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Statue 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: Bleck, White, etc. 72 hours after 1 Never Married 2 Merried 21215-0020 Specify: White 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filled within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Obituary Writer Boston Globe Newspaper Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: If them 27 is marked oth lury or other traumatic even 88 Collins Louise (un known) Paul 19e. tnforment's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Woodbridge, VA 22192-3706 Paul Fitzpatrick/husband 2704 Harwich Court 20a. Method of Disposition 20b. Plece of Disposition (Name of cematary, crematory or other place) Data 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removal from Steta Chesapeake Crematory, Inc. 1-17-00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Linehses 22. Nama end Address of Facility CAFA Stephen D. Lohnmenn, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximata Intervel Batween Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical OVARIAN Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the th Due to (or as a consequence of): 8 USB signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco usa contributa to the causa of geath? 1 Yea 2 No 3 Probably 4 Unknown Division of Vitai Records, Be Completed by 24b. Wara autopsy tindings available prior to completion of cause of death? page 2 should 24a. Wes an autopsy performed? 1 Yea 2 No certificata 1 ☐ Yes 2 ☐ No Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Wes case referred to medical 26. Place of Death (Check only one) STELLA HOSPICE MAKU Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident the 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the ceuse(a) end menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha time, data and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signato 29c. License number 29d. Date aigned (Month, Day, Year) M.030. Name and address of person who completed cause of death (Item 23a) (Type, Print) DWIGHT 51. BALTIMORE 21202 114 M.D. 301 31. Data filed (Month, Day, Year)

JAN 1 9 2000 32. Registrer's Signature State Registrar DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 14, 2000 Louise S. Griffith 8;00 AM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Elder Care- Longgreen N. Home Baltimore
| If Under 24 Hrs. |
| Hours | Min. if Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 M 2/7 Vrs 217-20-5059 Dec. 12,1916 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/a Baltimore XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5610 York Road, Epiphany House USA 21212 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Wallowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Textile Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John H. Walker Myrtle Weisman 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Larry Rigney, Jr. Friend 620 Dumbarton Avenue, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington 1/15/2000 Laurel, Maryland 21. Signeture of Juneral Service Licens 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fautre. List only one squise on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Final Diabete disease or condition resulting in deeth) Due to (or as a consequence of): mythma Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Sepsin Due to or as a consequence of): Dementia Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown finestive Joint Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Natising Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

that the death certificate be axecuted Box 68760. 0 ۵ Records, Division of Vital al or Attending Physician: The strending Physician: The strend death.

In Director: After this certificate of in by the funeral director, pa

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 238

Herns

ŏ

"naturs!',

1 and 2 should be filed within Health end Mental Hygiena. am 27 is merked other than

of Health Itam 27 i

permit. Pegas Department of Important: If it any injury or o

Physician /Medical

Examiner

Bud

bunal

the

ettending for usa as

the 2

signed b

page 2

pelli

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edical

Pegas 6 other

Direct

Funeral

by

Completed

traumatic event, the Madical Examiner must be notified at

the Maryland

Saltimore, Maryland 21215-0020

within 24 hours at To the Funeral D completely filled To the

State Registrar

1 9

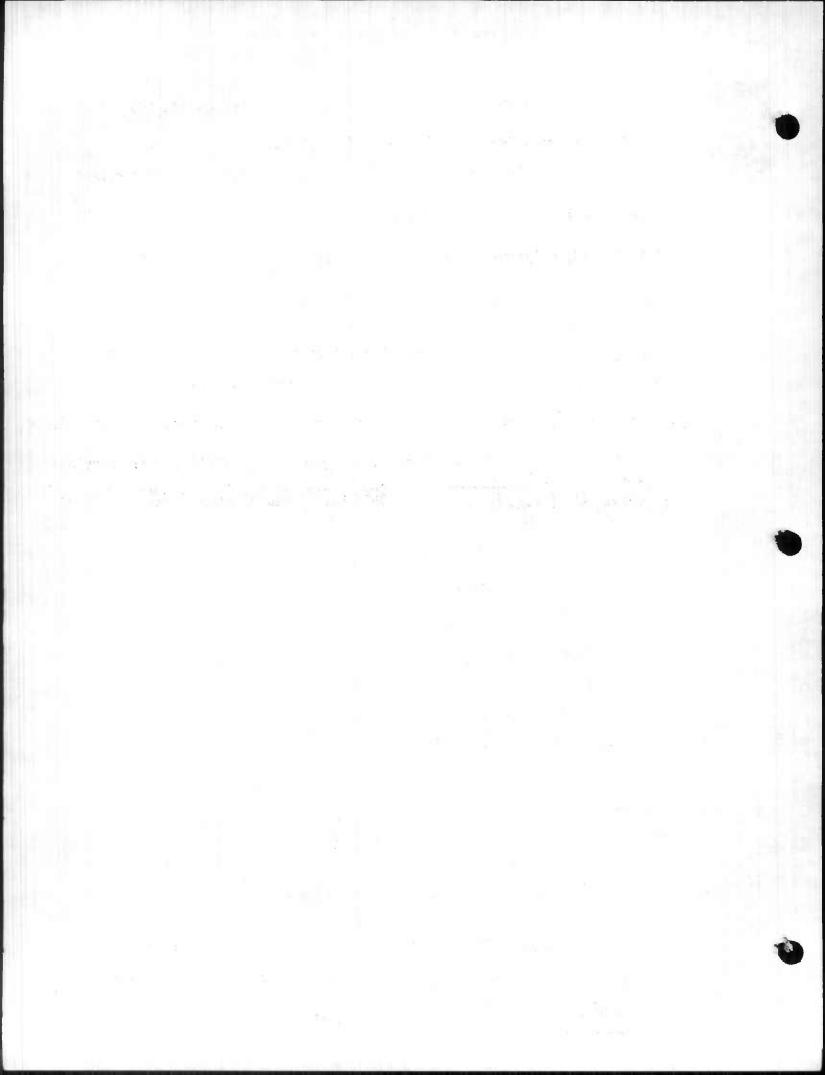
30. Name end address of person who completed cause of death (Item 23e) (Type, Print) HASHm1

821 32. Registrer's Signeture Denewa

Print) . Entan St fonte 30P, Balt. MD

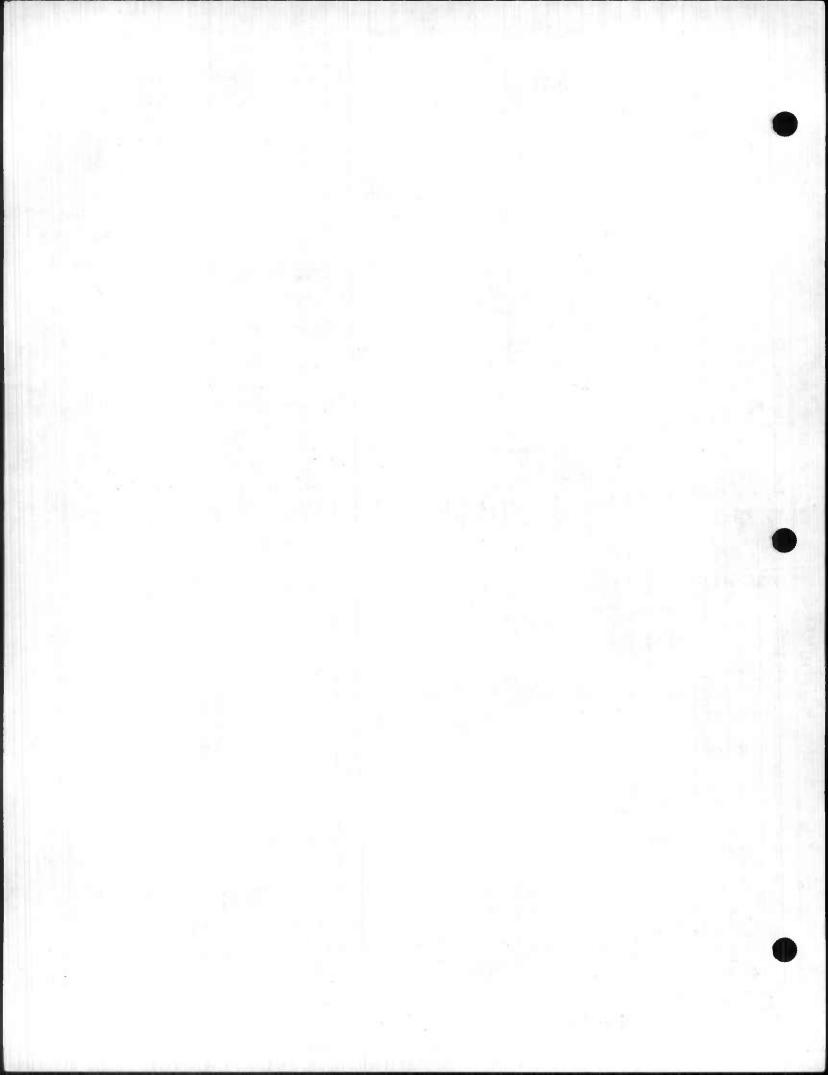
31464

1/14/00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

	4 December 10 Name (First Middle 1	41	Cei	tificate of	Death		No.	O Time of Death
ysician						Month	Day Year	
Medical			e Gent					4.20 111
aminer								P
eral	5. Social Security Number 6.	Sex 7. Age (In yrs. last birthday)		If Under 24 Hrs.			
ctor	220-12-1111	1UM 2K/F 92	Yrs.	MONTHS Days		Dec. 31,		
	Usual Residence of Decedent 10s. State 10b. County	1	Oc. City, Town or Lo	cation			1	IOd. Inside City Limits
unt be notified at rai Director	Maryland N/A	Donothy Louise Gent January 15, 2000 4:20 PM						
Directo	10e. Street and Number		5410111101	_		10g.	Citizen of What Cour	ntry?
al D	4119 Falls Road			2121	1		USA	
Funeral	11. Marital Status	12. Wes Decedent Eve	er in U,S. 13.	Was Decedent of I	dispanic Origin? (Spe	ecify Yes or No- Rican, etc.)		
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No				, ,		
	15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	pation	166	o. Kind of Business/In	dustry
ple	(Specify only highest gi				d) auring most of worki	ng		
Completed	10		Но	memaker				
Be	17. Fether's Name (First, Middle, Las							
2						- 4	,	2.11
	20a. Method of Disposition	ignter	20b. Plece of Dispo	sition (Neme of				
	Burial 2 Cremetion 3	Removel from State	-			/10/2000	Dikocyill	o Manylan
ian	· W	nplications that caused the consecution one cause on each line.	B 3	urgee-He 631 Fall or the mode of dyi	nss-Seitz s Road, Ba ng, such as cardiac c	altimore, or respiratory errest,	Maryland	Approximete Intervel Between
ical iner	Immediate Cause (Final disease or condition resulting in death)	a <u> </u>	ON 65	7100	MEAN	7 6	Home	
i i		A) RT1(STEN	2120		1	
edical Examiner	Sequentially list conditions,	0.					1	
E	cause. Enter Underlying Cause (Disease or injury	c						
9	that initiated events resulting in death) Last	Du	e to (or es e conseq	uence of):			i	
		d						
Physician/M	Dad ii Other elepitionat conditions	annishusing to double but a	at socition in the co	ndadina sawa si	una in Doubl	22h Didtoho	ann una annteltuta t	n the same of double?
hys	01-		not resulting in the u	noenying cause gr	ven in Part I.			
y P	17 TO COMON	017:					1000	
page 2 should be deteched for use Completed by Physician/N						24a. Wes an a	d? av	allable prior to
pie							00	empletion of cause death?
Con						1 ☐ Yes	211No 11	☐ Yes 212No
8	25. Was case referred to medical examiner?					(Check only one)		
2	1□ Yes 2⊡ No	Hospital: 1 Inpatient	2 ER/Outpatier	t 3LI DOA			e 8 Other (Specia	(y)
- LO	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Y	(ear) 28b. Time of Injury	Wo		28d. Describe how	injury occurred	
Cat	2 Accident investigation 3 Suicide 6 Could not l	DB Diese of Initial	At home form of		Yes 2 No	20f Location /Street	et and Number or Run	el Pouto Number
er in	4 ☐ Homicide determined	28e. Place of Injury building, etc. (Specify)	eet, rectory, omce		City or Town, S		ar House Warnber,
ptetery filled in by the funeral edical Certification:	29a. Certifier 1 Certifying P	hysician: To the best of n	ny knowledge, death	occurred et the ti	me, date and place	and due to the caus	e(s) and menner as a	stated.
adic ad	(Check only 2 Medical Exa	miner: On the basis of ex and manner stete	aminetion and/or in	vestigation, in my	opinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signature and title of certifier	1		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	M fed	Not,	MD	194	0867		1/18/00	
	30. Name and address of person who	ADOVNIK		Print) 3 8 6/1	leen Tro	t rd	BATTERM	ROSIZ OM 3
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature A.	Kna "	61			
gistrar	IAM 1 Q 2	UUIII	/w/ ·	1645 CACO	2			



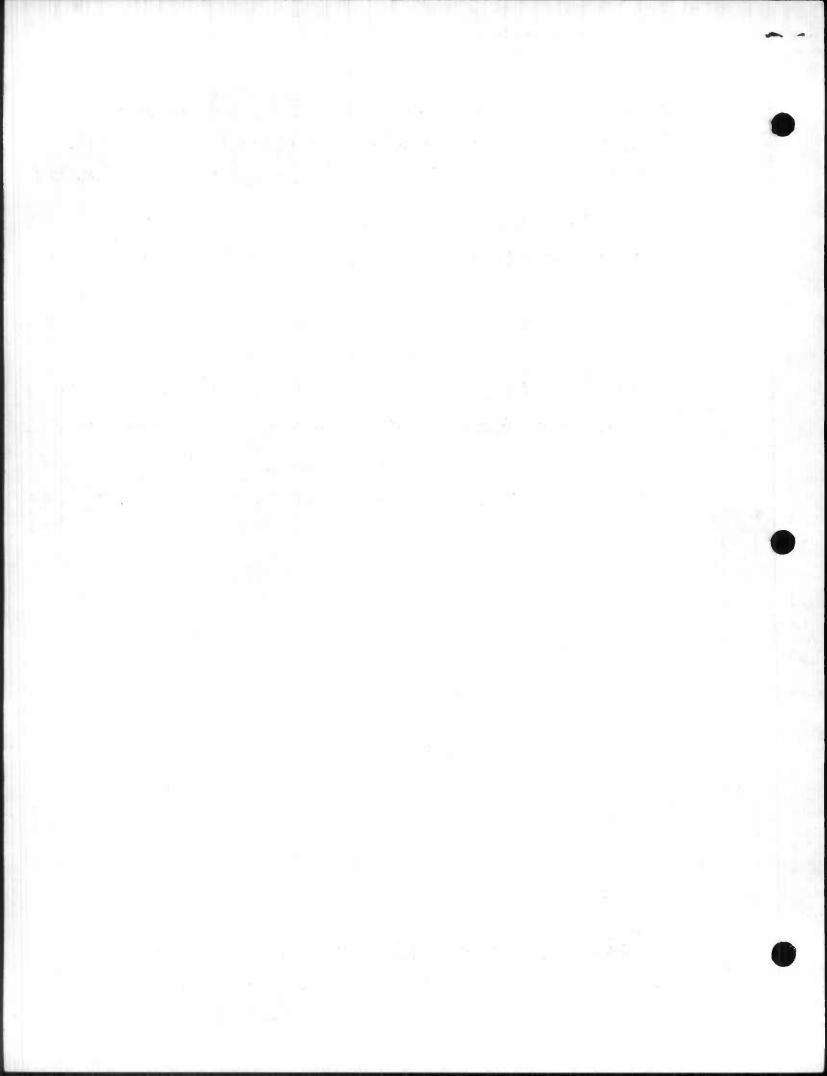
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** Month 10 /Medical KIV 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Himor lanor If Undar 1 Yaar last birthday) 5. Social Sacurity Number 6. Sax 9. Birthpiaca (Stata or Foraign **Funeral** Days Hours 100M 20F Director Usual Rasidance of Dacedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Impropriant: If item 27 is marked other than "naturel", or items 28s or 28s-f show any injury or other traumetic event, the Medical Examiner must be maritimed. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director IMONIUM 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 146 Funeral 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Navar Marriad 2 Married 1 XYas 2 No Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XNo þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) employment 18. Mothar's Nama (First, Middle, Maidan 17. Father's Nama (First, Middla, Last, Be Informant's Neme/Raiationship 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10 IMONIUM 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition San. 21 1 ⊠Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) vans 2325 BRK Far1. Entar tha disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in daath) relo reace Examiner due to (or as a consequance of): Examiner buriel-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that Initiated evants rasulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Dua to (or as a consequence of): 88 USB 0 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of causa of daath? Completed peen has page 2 2 No After this certificate 1 Yas Hospital or Attending Physician: director. 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Megnar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding 1 Tas 2 🗆 No death. 2 Accidant invastigation efter death 6 Could not be 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours e 29e. Certifier (Check only one) The Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. Medical within 2 To the 29b. Signatury and stay of certifie 29d. Data signed (Month, Day, Year) 0

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month

And



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth GROVAC 7.45 AM 0 CLARA 2000 4e Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) APR 26, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) Days Hours 10 M 20 F Months 213-14-2548 80 1919 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Rockville 10a. Street and Number 10g, Citizen of What Country? 10f. Zip Code 1235 Potomac Valley Road 20850 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) US Treasury Department Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Scoggins Rose Merritt 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) (guardian) 401 Hungerford Dr., 2nd Fl., Rockville, MD 20850 Patricia Wilczek 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 01/18/2000 Washington DC 21. Signeture of Fonerel Service Hoensee 22. Name and Address of Facility Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20910 Approximete intervel Between Onsat and Death Immediate Cause (Finel disease or condition resulting in deeth) SEPTICEMIA Due to (or es a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 200 No 3 Probably 4 Unknown CONGESTIVE NKART BAILURE 24b. Were autopsy findings available prior to 24e. Wes an eutopsy performed? INPECTION completion of cause of death? RENAI 1 Yes 2 No 1 ☐ Yes 2 ☐ No PAILURE 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Menner of Death 28d. Describe how injury occurred 28h Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Netural 5 Pending Investigation 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed physician s the buriel Box 68760. signed by the at the detached for P.O. Division of Vital Records, should page 2 certificate or Attanding Physician: funaral director, this After after death. Director: Af

Examine Physician/Medicai by Completed Be Certification: To filled in by

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

28e-f

mast be 8

the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within 72 ht nent of Health and Mental Hygiene. ent: if Hem 27 is marked other than "nettur ary or other traumatic event, the Medical.

Physician /Medical

Examiner

Baitimore, Maryland 21215-0020

State Registrar

completely

(Check only one) 29b. Signatura and titla of certifier

6 Could not be determined

3 Suicide

29e. Certifier

Medical

4 Homicide

TIPAPORN

29c. License number

17656

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE 4550 CHEVY CHASE, MD 20815 MISCONSIN

M.D MOODERAR 5530 /32. Registrar's Signeture

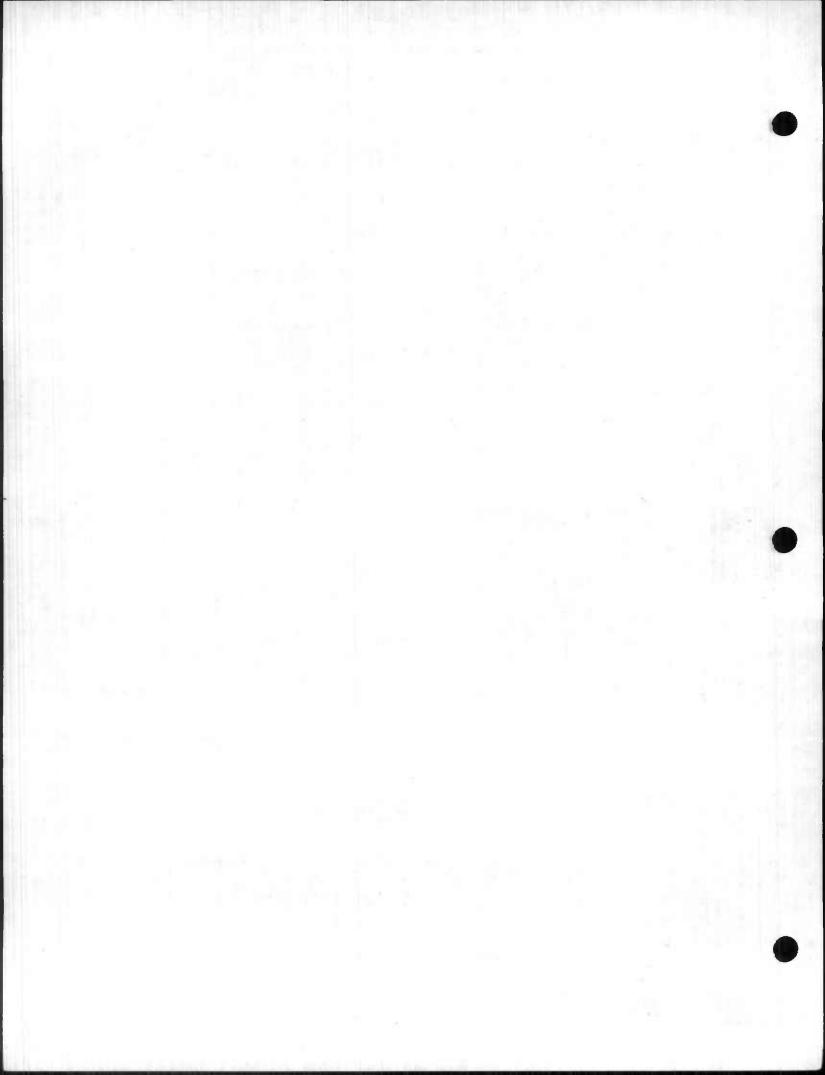
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

oaks

24 hours a Hospital

within 2 ş

0



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Year Gutknecht Revnold 4:40 AM 2000 JANUARY 16 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Mariner Health Care - Bel Air If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day Year) Jan. 16, 2000 5. Social Security Number 6. Sex 1 MM 2 ☐ F 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 92 Poland 219-14-1801 Usual Residence of Decedant 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Baldwin Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21013 13728 Baldwin Mill Road 14. Race - American Indian Black, White, etc. 12. Was Decedant Ever In U.S. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 Yas 2 No Specify: 3 Widowed 4 Divorced Year or Datas: 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Electric Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Bertha Petrick **Gutknecht** Gistav 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 13728 Baldwin Mill Road Baldwin, MD 21013 19a. Informant's Name/Relationship (Type, Print) Catherine Gutknecht/wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-16-00 Beltsville, MD Chesapeake Crematory, Inc. 22. Name and Address of Facility CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 21. Signature of Funeral Service Ligensi 23 Tart1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Daath ALLIdent Immediata Causa (Final disaasa or condition resulting in death) Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in daath) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? 2 No 1 TYPS 2 No 1 Yas 25. Wes cese referred to medice examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident

Examiner GOT KNECHT,

Division of Vital Records, P.O. Box 68760 been signed by the a should be datached f cata has been sig After this certificate Hospital or Attending Physician: funeral director, To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completaly filled in by the

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

Funeral

Director

r than "natural", or items 23s or the Medical Examiner must be a

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int. If Nem 27 is marked other than "natural", or the

7 is marked other traumatic event, t

Important: If It any injury or

Physician

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

3 Sulcida

29a. Cartifian

4 HomicIda

Baltimore, Maryland 21215-0020

the Maryla

State Registrar

29b. Signatura and titla of certified

6 Could not be datarmined

 n_D

D31652

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to tha cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama end addrass of person who complated cause of death (Item 23a) (Type, Print)

Avenus

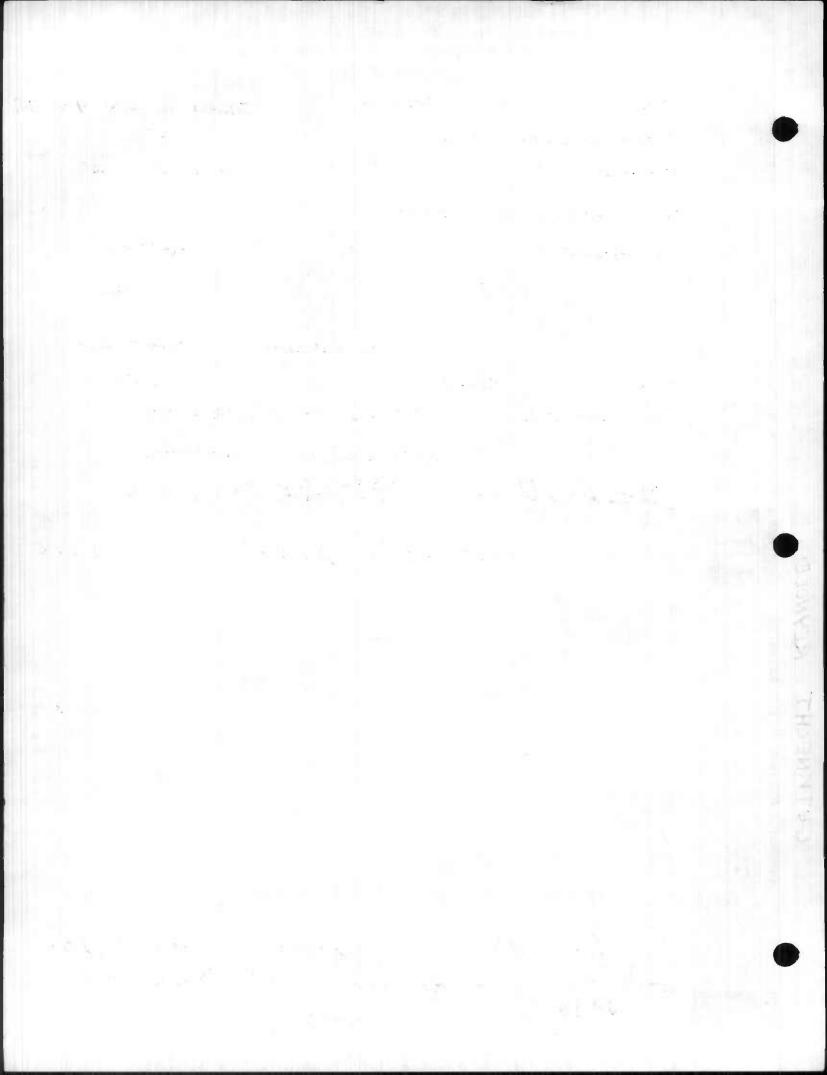
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Bel Air Manyland 21014

31. Date filed (Month, Day, 1 1 9 2000

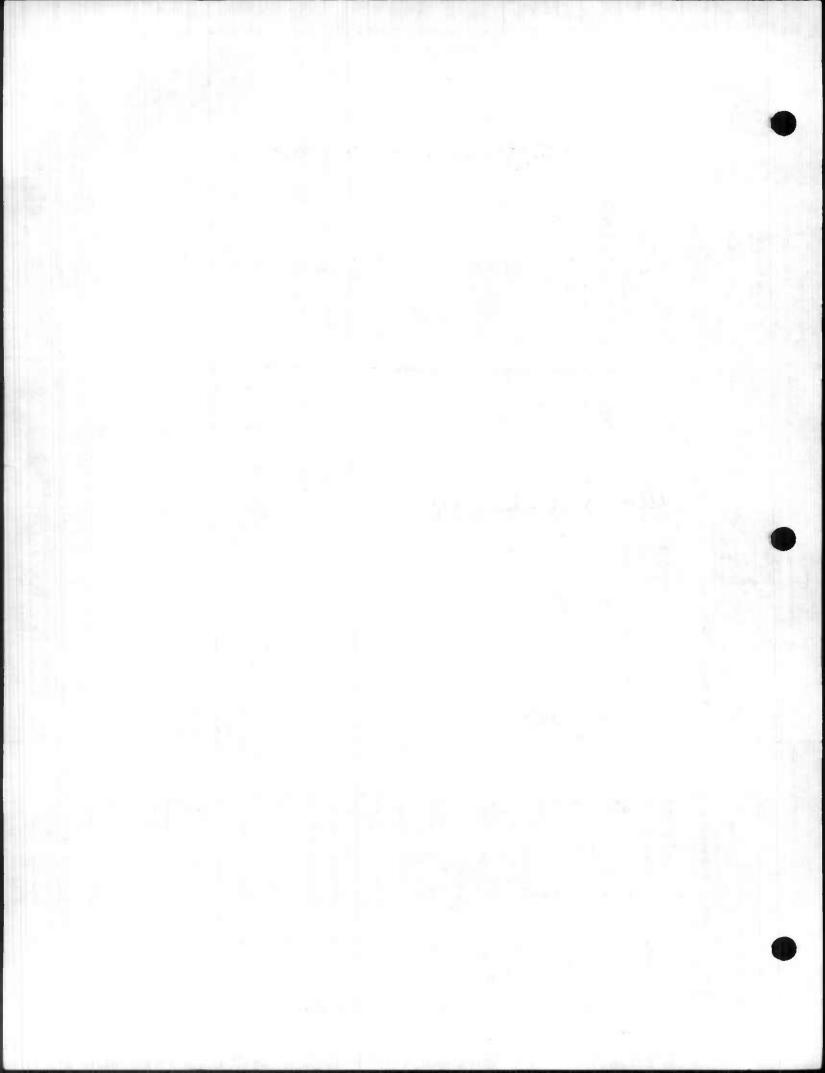
32. Registrar's Signature

29c. License number



PER State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #29C, PER AMEND ITEMS: #30 PER V.R. G779 1-7-2000 dificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Month **Physician** 16:41 Marguerite E Hughes Mornary 1,2000 /Medical 4a Facility Neme (II not institution, giva street and number) 4b. City, Town, or Location of Death 4q. County of Death Union Memorial Hospital Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 31,1923 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F Yrs. 213 20 5188 76 Director Baltimore, Maryland Usual Rasidanca of Dacedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore City Directo Maryland Roland Park 28a-f 90 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8 2 # 23m 111 Hamlet Hill Road 21210 USA Funeral 14. Race - American Indian, 11. Marifal Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: À 3 ₩ Widowed 4 Divorced White Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiana. Elamentary/Secondary (0-12) College (1-4or 5+) WA Administrative Assistant Association of Commerce Baltimore, Maryland 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental H ant: If Nen 27 is marked off jury or other traumatic even Be William G Baker Adeline Matilda Tuerk 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Thomas R Hughes (Son) 12808 Morrison Road Little Rock, AK 72212 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 Cremetion 3 Ramoval from State Department of supportant: If any injury or other St John Luth. Ch. Cem. January 5,2000 4 Donetion 5 DOther (Specify) Baltimore, Maryland 22. Neme end Address of Facility 21. Signature of Funaral Service Licensee lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** 12 hours /Medical Immediete Cause (Finel Anoxic Brain diseasa or condition resulting in death) Examiner Due to (or as a consequence of) 3 month Examiner Arter Onara Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of pue Box 68760. Completed by Physician/Medical the Due to (or es a consequence of): 980 Pert II. Other algniffcant conditions contributing to daeth but not resulting in the underlying cause given in Pert f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart railure Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? mellitus Atrial noitallindil 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attanding Physician: Be 25. Was case raferred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be datermined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stafed. Within 2 \$ 29b. Signetura and fittle of certifier 29c. License number P11855 29d. Date signed (Month, Day, Year) 0 MD Zomora 1. 3000 30. Nema and address of person tho completed causa of teath (Item 23a) (Type, Print) ANTHONY DORSEY UNION MEMORIAL HOSPITAL 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 2000 Registrar **DHMH 16 Ray 6/95**

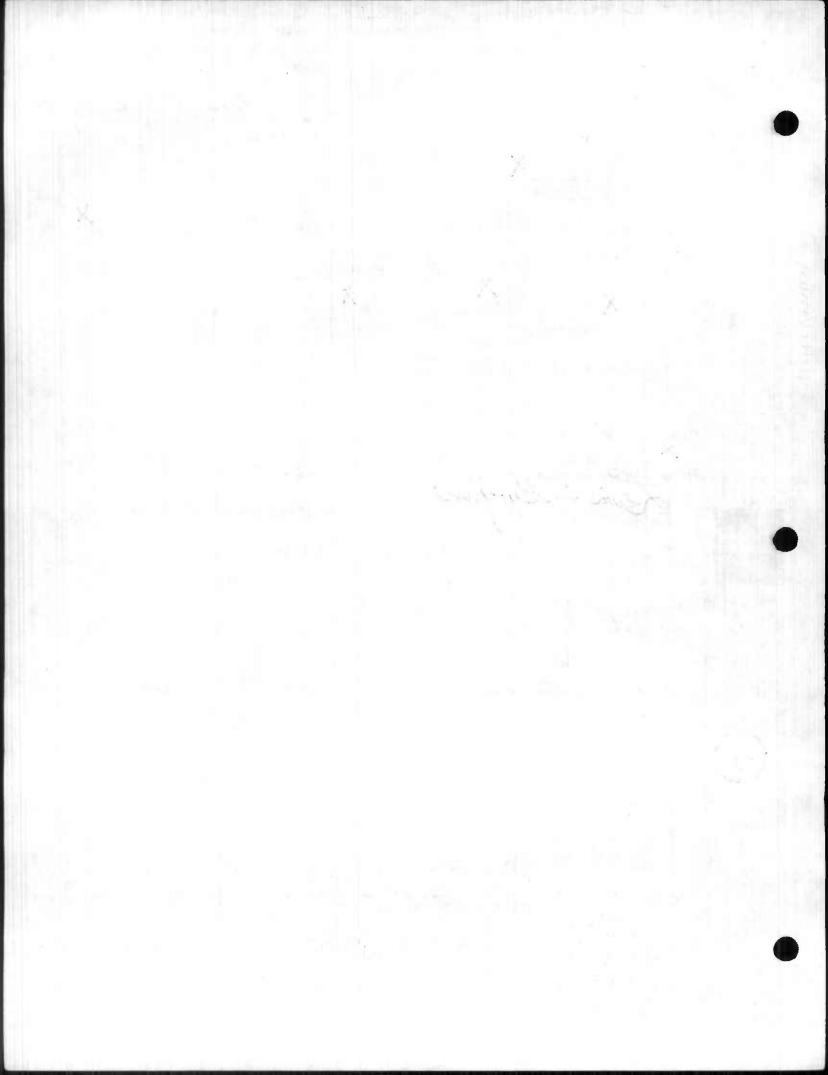
ORIGINAL



Please Type or Print in Black Indellble Ink. Assure All Copies Are Legibie.

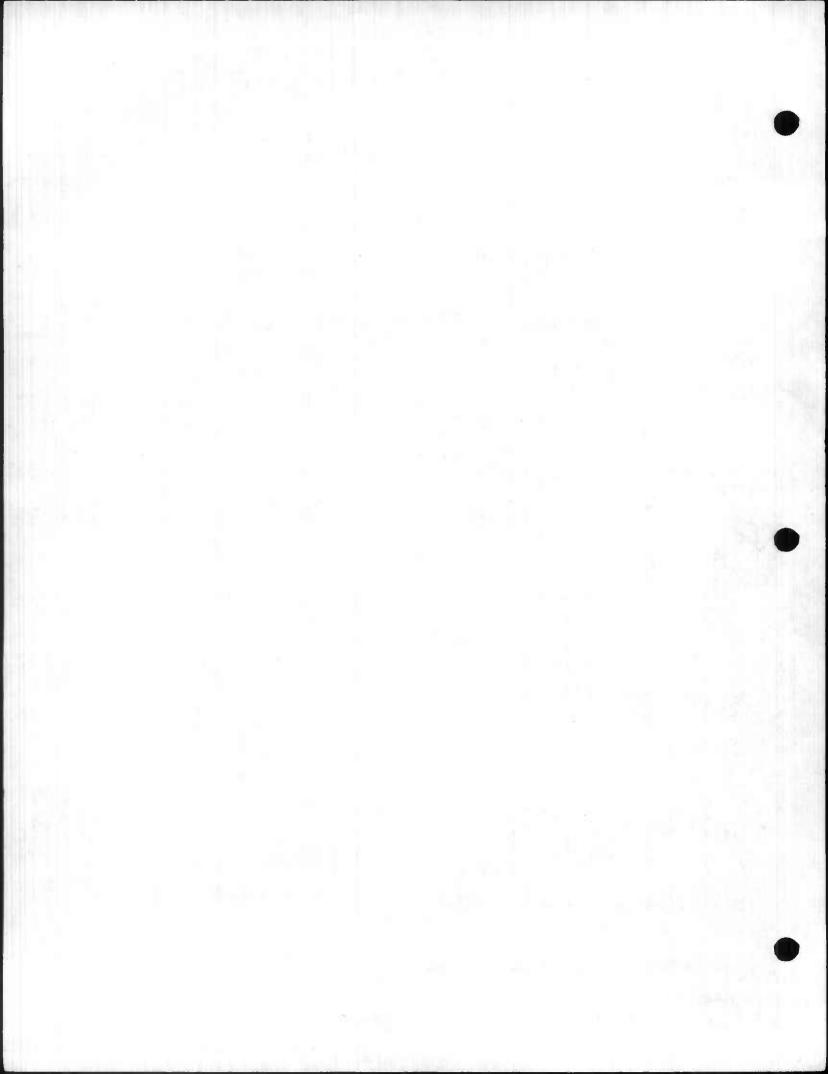
State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #23a PER MD G779 1/19/2000 AH 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 6:10am VIVIAN MARIE HILL 12000 4b. City, Town, or Location of Death 6 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Hospita Bultimore If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Days Months 213 34 3646 72 Director SEPT. 27, 1927 VIRGINIA Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28e-f N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 4502 PIMLICO ROAD APT. 2B 21215 U.S. OF Α. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: BLACK 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) YEARS 12TH SCHOOL TEACHER PUBLIC SCHOOLS 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental RICHARD PRICE ESTHER CARTER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Oppartment of Health and Agroportant: If Item 27 is m many Injury or other traum SHERRY JOHNSON (DAUGHTER) 2809 NORFOLK AVENUE BALTIMORE, MD. 21215 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Burial 2 Cremetion 3 Removel from Stete MT. ZION CEMETERY 1/10/2000 BALTIMORE, MARYLAND 21. Signature of Union Service Liquidade 22. Name end Address of Facility **GWYNN** LEWIS T.GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE enter the mode of dying, such as cardiac or respiratory errest, BALTO MD 23a. Part1. Enter the disease, or complications that consed the death. Do not enter shock, or heart feilure. List only one cause on the line. Intervel Between Onset and Death Physician gan Failure /Medical Immediate Cause (Final disease or conditio resulting in death) Examiner SEPSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): P.O. Box 68760 that the death certificate be Physician/Medical Due to (or es a consequence of): Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yea 2 ☐ No Division of Vital Records, à 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 25. Was case referred to medical certifi 88 28. Place of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA # 27. Manner of Deat 1 ONatural 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Athar 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 T Homicide To the Hospital within 24 hours a To the Funeral D edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner as stated.

Under the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of cortifie 29c. License numbe 29d. Date signed (Month, Dey, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) indi Hospital 31. Date filed (Month, Day, Year) Registrar's Signetur State JAN 1 9 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 2 2

	1. Decedent's Name	(First, Middle, Las)			tificat				2. Date of Dec		Van	3. Time o	d Death
ian ical	Leroy	34 50 m	Hugg	ins				7		JANHARY	Day	Year Z v o U	3:23	PM
iner	4a Facility Name (H)						4b. City, Town, or Lo				4c. County	of Death		
			1 Hospi	tal				Balti			N	A		
	5. Social Security Nur 214-44-	3073 X	X 7. A ☐ M 2☐ F X	ge (In yrs. 57	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 04-24		9. Birthp Coun	slace (State stry) SC	or Foreign
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											1	Od. Inside (City Limits
tor	MD	NA		В	altim	ore							1 X Yas	2 No
Funeral Director	10e. Street and Numb 2617 N.	Dai											itry?	
6	11. Marital Status X資Never Married 3 □ Widowed 4		12. Was Deceden Armed Forces 1 Yes 2 M If Yes, Give Year or Dates	? No		Vas Dece Yes, spe ☐ Yes		lispanic Orig an, Mexican, Specify:	jin? (Spe , Puerto f	cify Yes or No- lican, etc.)	14. Rac Blac Specify	e - Americ ck, White,		
0		5. Decedent's Edu			16a. Deced	ent's Usu	al Occup	etion	of workin	10	16b. Kind of B	usiness/Inc	dustry	
Completed	Elementary/Secondary (0-12) Unknown		College (1-4or	5+)	Disabled			lone during most of working etired)			Disabled			
	17. Father's Name (F							18. Mother	r's Neme	(First, Middle,	Maiden Suman			
0			nown					Lill	Ly	Mae I	Huggin	S		
0							ess (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2.1.						1212	
	Joseph	Anastas	io-Care	take	r c/c	о В.	A.R	.c. 7	7215	York	Road I	Balt	imore	e,MD
	Joseph Anastasio-Caretaket c/o B.A.R.C. 7215 York Road 20a. Method of Disposition 1XI Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Voshell Mem. Gardens 01-20-2000									20c. Location -	ation - City or Town, State Dundalk , MD			
Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (Fidisease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underhouse. Enter Underhouse (Disease or in that initiated	nal		EASIS Due to (o	Do not ente	er the mod	de of dyir	rch F	CH 1	101 E	Nort	h Av	Approximatinterval Be Onset and	Death
	Cause (Disease or in that initiated events resulting in death) La	c												
l			contribution to doubt but not enculting in the unclocking occurs							1	b. Did tobaccours contribute to the a			
	Part II. Other elignificant conditions contributing to death but not resulting in the underlying ca						g cause given in Part I. 230.				b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4			
	SEIZURES.								_	24a. Was an autopsy performed? 24b. Were autops available prio completion of death?			ailable prior mpletion of	to
										101	res 2 No	1[Yes 2] No
	25. Was case referre		Hospitat: 🎣				100		of Death	(Check only o	ne)			
	1 ☐ Yes 200 N 27. Manner of Death 1 Matural	5 Pending investigation	28a. Date of In (Month, D	urv	ER/Outpatient 28b. Tima of Injury		28c. Inju	y at	2	Home 5 ☐ Residence 6 ☐ Other (Special Describe how injury occurred			y)	
	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	ot be							28f. Location (Street and Number or Rural City or Town, State)			al Route Nu	mber,
edical Certification:	29a. Certifier 1. (Check only 2 one)	Certifying Phy Medical Exami	sician: To the besiner: On the basis and manner s	of examinat	wledge, death tion and/or inv	occurred estigation	at the ti	ne, date and pinion, deat	d place, a h occurre	nd due to the old at the time,	cause(s) and modate end place,	anner as s and due to	tated. the cause	(s)
E	29b. Signature and M	le of collision				29	c. Licens	e number			29d. Date signe	d (Month,	Day, Year)	
	17	4/	MD.				ATZY	138946	J÷.		JANUARY 16 ZOU			
	30. Name and address	1	MEMULAL				IVERS		KY	21213				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** HARBISON 00:29 JESSE JANUAR 4 MAE 2000 15 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BATTMORE CITY If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10 M 20 F Hours 16-80 Director Usual Residence of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or Nama 23a or 28a-f ahor the Medical Examiner must be notified at 1 Yes 2 No Director land nore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral death v Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race -American Indien. 11. Marital Status Bieck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 2 X No 21215-0020 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Yeer or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Baltimore. Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be nent of Health and Mental 0 0 19a, informent's Name/Reletionship (Type, Print) (Husband) 19b. Meiling Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum once. d. 21216 moun 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition / Date/ 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 12008 4 Donation 5 □ Other (Specify) 21. Signetule of Funerel Service Licensen 22. Name and Address of Facility RUSS Hom Joseph Bai une Ave 22 22 W. North 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediete Cause (Finei 24 HRS MYOLARDIAZ INFARCTION disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner ONE WEEK burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): The law requires that the deeth certificate be execu P.O. Box 68760, STROKE TWO NEEKS Physician/Medical the Due to (or es a consequence of) 88 been signed by the a should be detached i Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? page 2 219-No certificata 1 Yes 1 ☐ Yes 2 HINO of Vital Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Ginpatient this illed in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After Division 1/ Naturai 2 Accident 5 Pending investigation 1 Yes 2 No death. within 24 hours after deati To the Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Lawoell & MID RES-000 January 15,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE MARYLAND 21287 JOHNS HOPKING HOSPITAL TOWER 110

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) JAN 19 2000 32 Registrar's Signature





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Date of Death January 17, 2000 Hartlove 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore If Under 1 Yaer | If Under 24 Hrs. | 8. Data of Birth Months | Days | Hours | Min. | March 10, 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Months 63 Yrs. Maryland 10c. City, Town or Location Baltimore

Funeral Director

28a-f ahow r than "naturel", or hems 23a or 28a-f ahon the Medical Examiner must be notified at herns 23a naturel', or 27 la marked other ti r traumatic avent, to and Mental permit. Pages 1 and 2 is Department of Health ar Important: If item 27 is eny injury or other trau pince.

filed within 72 hours after death

Saitimore, Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental Physician

The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760. certificate or Attending Physician: hours after death.

neral Director: After this ce
filled in by the funeral dire

/Medical

Examiner

D

within 24 hours a To the Funeral D completely filled Hospital

State

edicai

31. Deta filed (Month, Day, Year) Registrar 1AN 19

4 Homicida

29b. Signature and title of certifie

29e. Certifier (Check only one)

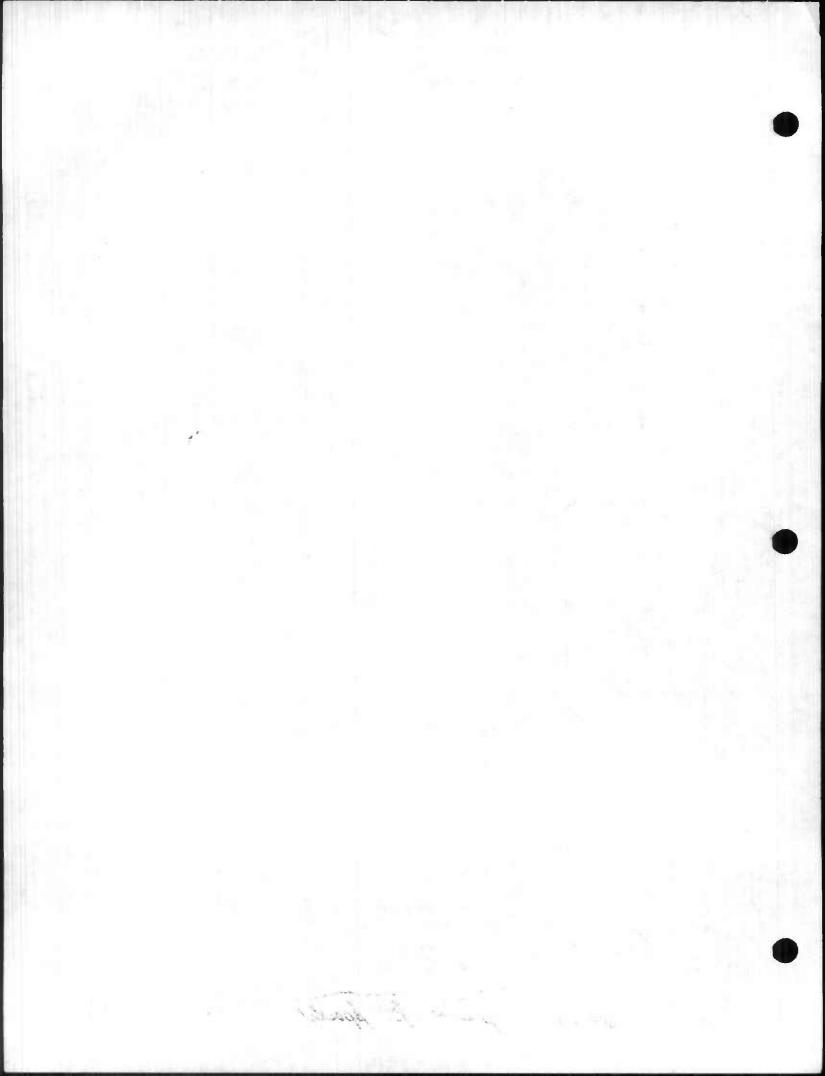
32. Registrar's Signetura

1. Decedent's Nama (First, Middla, Last) **Physician** Joseph George 5:45AM /Medical 4a Facility Name (If not institution, give street and number) Examiner Sinai Hospital 5. Social Security Number 9. Birthplaca (Stata or Foraign 217-32-8910 Usuei Rasidenca of Decedant 10a. Stata 10b. County 10d. Inside City Limits N/A MD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21208 United States 3322 Shelburne Road Funerai 12. Was Decedent Evar in U,S. Armed Forcas? 1 [A Yas 2 □ No If Yas, Giva Year or Dates: Korean Race - Amarican Indian, Biack, White, atc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 Never Merried 2 Merried Specify: White 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Coilega (1-4or 5+) Electric 12 Mill Wright 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Julia McElroy Charles L. Hartlove 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 3322 Shelburne Road, Baltimore, Maryland 21208 Mrs. Eleanore D. Hartlove/Wife 20b. Plece of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 01/21/00 Baltimore, Maryland Druid Ridge Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Address of Facility Leonard J. Ruck, Inc. 21. Signeture of Funarai Service Licensee Michael E. Canapp 5305 Harford Road, Baltimore, Maryland 21214 Mica 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervei Batween Onsat and Death Immedieta Causa (Final diseasa or condition rasulting in death) . Intracranial Hemorrhage 2 Hours Due to (or as a consequence of): Physician/Medical Examiner Sequantially list conditions, if any, laading to immadieta cause. Enter Undarlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of) Dua to (or es a consequance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evailabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Placa of Deeth (Check only one) Hospital: 1 XInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yes 2 No 2 27. Mannar of Death 1 DNatural 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation 1 Yas 2 No 2 Accidant 28f. Location (Straat end Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, streat, fectory, office building, atc. (Specify)

29d. Data signed (Month, Day, Year) 29c. Licansa number Res - 000 January 17, 2000

30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

Craig Singer, 2401 W. Belvedere Avenue, Baltimore, Maryland 21215



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan 2000 ARTHUR E, +11CKS 6:02 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL HOWARD If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days 1 M 2□ F Hours 89 213-09-3630 NOV. 13,1910NORTHCAROLINA **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND HOWARD **JESSUP** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8123 HICKS ROAD 20794 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, etc. 11. Meritel Status

1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) MED OLIDARIA

SELF EMPLOYED

20b. Place of Disposition (Name of cemetery, crematory or other place)

1412 E.

MECHANIC

CONSTRUCTION

FANNIE

8867 E.ROLL RIGHT CT. COLUMBIA, MD 21045

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

JAN. 17,2000

MEADOWRIDGE MEMORIAL PK. HOWARD CO, MD.

22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME

PRESTON STREET

MORTH DV. COlumbia MD

18. Mother's Neme (First, Middle, Maiden Sumame)

AERO-AMERICAN

16b. Kind of Business/Industry

CONTRACTOR

20c. Location - City or Town, Stete

Approximete Interval Between Onset and Death

24b. Were autopsy tindings evailabla prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

21045

Physician /Medical Examiner

Physician

/Medical

10a. Stete

1 Never Merried 2 Merried

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

3RD

UNKNOWN

20a. Method of Disposition

17. Fether's Neme (First, Middle, Last)

19e. Informent's Name/Reletionship (Type, Print)

ARTHUR E. HICKS, JR.

21. Signature of Funeral Service Licenses

1 Burial 2 Cremation 3 Removet from Stete 4 Donation 5 Other (Specify)

Directo

Funeral

å

Completed

Be

Examiner

Funeral

Director

show

288-4 å

6

23a

Normal

Pages 1 and 2 should be filed within 72 hours after nam of Health and Mental Hyglens.
Int. If flam 27 is marked other than "natural", or fla

Hygiens.

n of Health a If Barn 27 is or other tra

Department of important: If any Injury or

21215-0020

Baltimore, Maryland

Attending Physician: The law requires that the deeth certificate be executed pue physician 950

Box 68760

Records, P.O.

Division of Vital

funeral director. this After To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director; A completely filled in by the fu deeth.

23a. Pert1. Enter the disease, or complications that caused the deathy De not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. tmmediete Cause (Finel Neumonia diseese or condition resulting in death) Due to (or as a consequence of): Examiner DRTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): TYPERTENSION Physician/Medical Due to (or as a consequence of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown δ Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 TYes 2 □ No invastigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of tnjury - At home, ferm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signeture and tree of contifier 29c. License number 29d. Date signed (Month, Day, Year) 42465 Jan. 14, 2000

1 Yes 2 No

College (1-4or 5+)

Year or Dates:

DHMH 16 Rev 6/95

Registrar

31. Dete tiled (Month, Day, Year)

JAN 1 9 2000

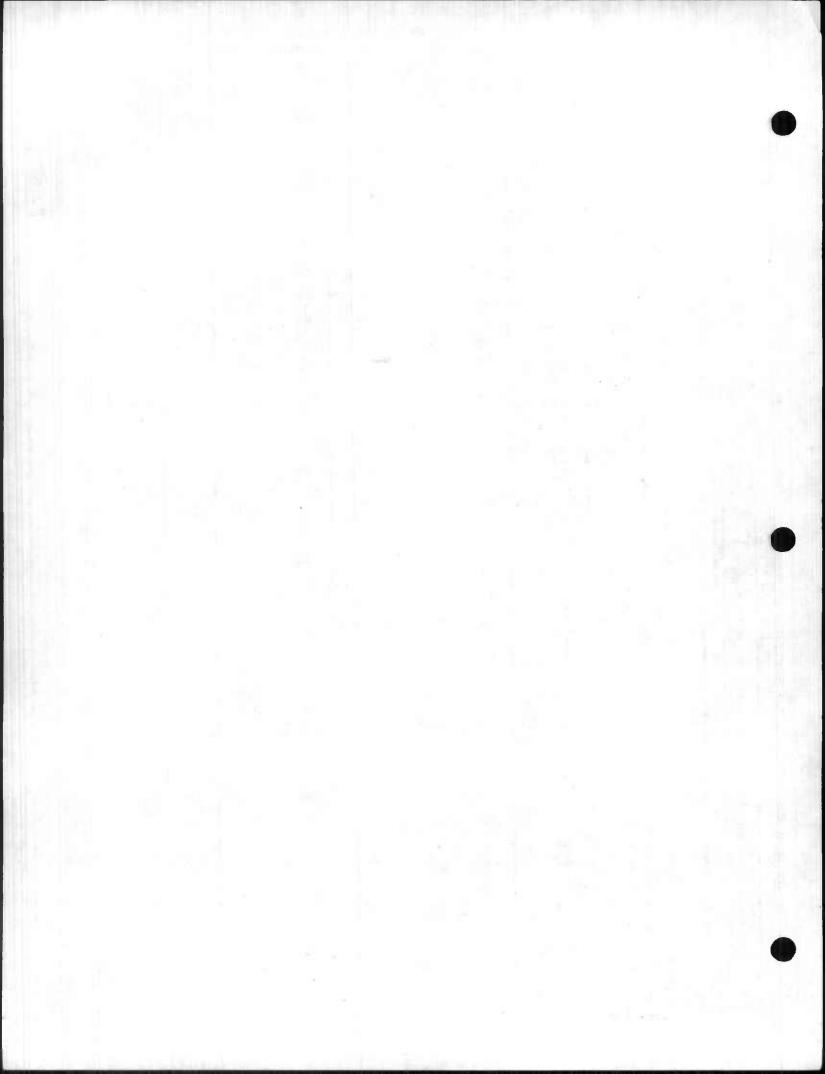
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAMAYMD

32. Registrar's Signature oaks

2Knoll

ORIGINAL



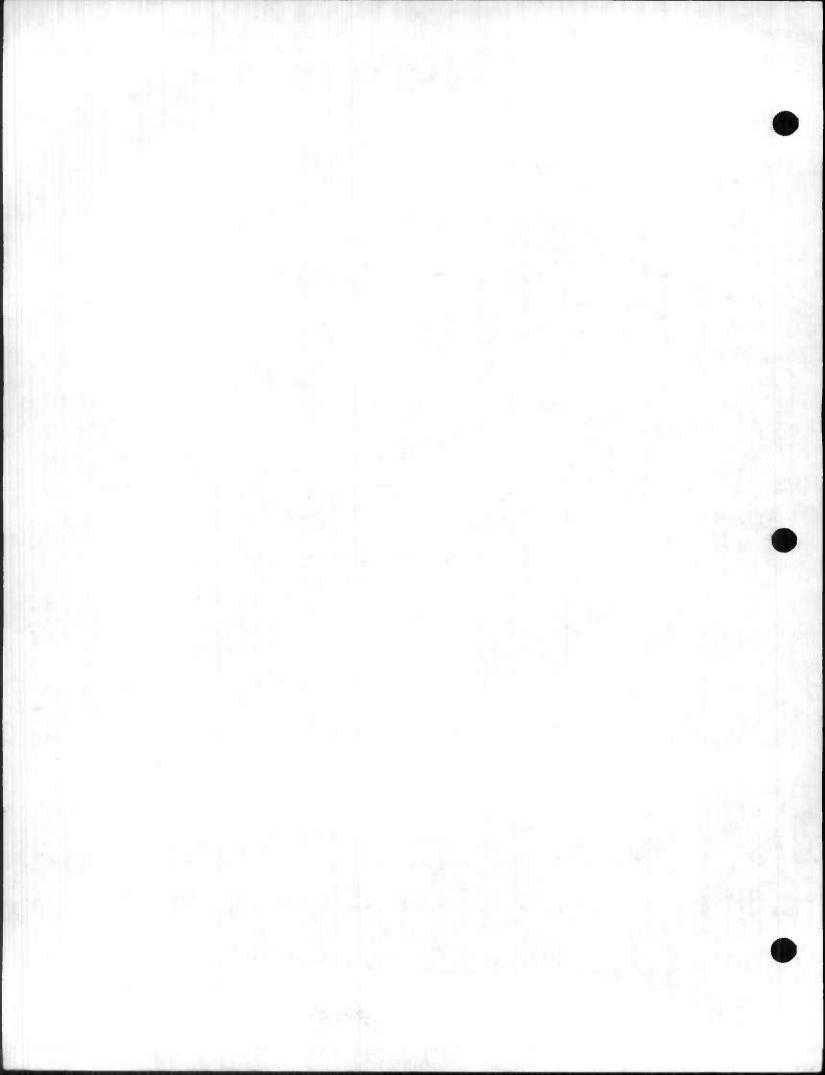
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00	01	0	0	1
00	U	U	O	1

			(Certifica	ite of	Death		R	leg. No.		0100
	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea			3. Tima of Deat
Physician	HARRY LE	E HARDEI	Z.					Month January	Day 11, 2	Year 000	7:35 A.
/Medical	4a Fecility Name (If not institution,					4b. City, To	wn, or Loc	ation of Death			7.33 A.
Examiner	1307 Argyle Ave	and the state of t		tmont			imore		,		
			ge (In yrs. last birth		er 1 Year					N/A	olege /Ctete or For
uneral rector	219-18-1315	1 X M 2 F		Month:		Hours	Min.	8. Date of Birth (Month, Dey JAN 17			place (State or For htry) YLAND
	Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	or Location						1	Od. fnside City Lin
P P					O.T.						XXYes 2
ell lie	MARYLAND N/A		BAL	TIMORE		ζ					
ner must be notified at uneral Director	10e. Street and Number			10f. Z	ip Code			1	log. Citizen of V	What Cour	ntry?
E # 2	1307 ARGYLE AV	ENUE		2	1217				U.S.A		
iner met	11. Merital Stetus	12. Was Deceden Armed Forces		13. Was Dec	edent of I	Hispenic Orl	gin? (Spe	city Yes or No- lican, etc.)	14. Rec	a - Americ	
게 L	1 Never Merried 2 Merrie	d 1 Types 2] No		2/20%			mount, oto.,			oic.
by	3 ☐ Widowed 4 X Nivorced	If Yes, Give Year or Dates	:42/45	1 U Yes	2123-440	Specify:			Specify	ACK	
Completed	15. Decedent's		18a. C	Decedent's Us	ual Occu	pation			16b. Kind of B	usiness/In	dustry
ple	(Specify only highest			Give kind of v life. DO NOT	vork done use retire	during mos d)	t of workin	9			
E C	Elementery/Secondary (0-12)	College (1-4o		CONSTRUCTION WORKER					CONST	RUCTION	
	10th grade 17. Father's Name (First, Middle, L	est)	1	OINDIINO	CIIOI	-		(First, Middle.	Meiden Sumen		
Be		,								,	
2	JOSEPH HARDEN							HARDEN			
	19a, Informant's Neme/Reletionshi		19b.	Mailing Addre	ss (Stree	t end Numb	er or Rura	Route Numbe	r, City or Town,	Stete, Zip	Code)
	June Harden/Dau	ghter	1	122 HA	NI)Y Z	AVENUE	, CAJ	VIONSVI	LLE, MA	RYLA	ND 21228
	20a. Method of Disposition		20b. Place of I	Disposition (No. cremetory of	lame of	ice)		Dete	20c. Location -	City or To	own, Stete
	120 Surial 2 Cremation 3		GARRIS				11.	-19-00	OMINICS	MTTT	S, MARYL
	21. Signature of Funeral Service L		GAIGATS			ess of Facili		-19-00	ONTINGS	LITTU	S, MAKIL
8508	1 Marsare	11. Bu	Mos		AM C	BROWN	COM	MUNITY	FUNERAL	HOM	E PA
	23a. Pert1. Enter the disease, or coshock, or heart failure. List o	omolications that cause	ed the deeth. Do no					r respiratory ari	rest		Approximate
s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as a consequenca of):								
6 =	resulting in death) Last										1485
d by Physician/N	Part II. Other afgniffcant condition	ven in Part	l.	23b. Dld t	ld tobacco usa contributa to the cause of deat						
Phys						101	1 Yes 2 No 3 Probably 4 Yuni				
100								04- 111		7.4h 144	lara sutanas findia
Completed								24e. Was a perfor	an eutopsy med?	av.	ere autopsy findin vailable prior to empletion of cause
. 0								Inspe	ection	of	death?
To Be Com								1 🗆 Y	es 2 No	11	Yes 2 No
	25. Was case referred to medical					26 Place	e of Death	(Check only or	ne)		
o Be	examiner? 1 □XYes 2 □ No	Hospital:	ы а∏ ЕВ/Оы	nations all	Ot Ot	her:				-a= (Casa)	4.1
	27. Manner of Deeth	1 ☐ Inpa 28a. Date of In (Month, D			28c. Inju				lence 6 Ott		197
atio	1 Natural 5 Pending 2 Accident investiga		111	М		Yes 2	No				
Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Place of I	9 29a Place of lating. At home form at root factors office					28f. Location (S City or Tow	Street and Numi m, Stete)	ber or Run	el Route Number,
edicai C	(Check only 2 X Medicat E	Physician: To the bes	of examination and								
Medical Cert	one)	and manner s	stated.		On None				20d Data sians	d /Manth	Day Vess
8	29b. Signeture and title of certifier	1 00		2		se number	-		29d. Date signe		
	Dennis	1. Church	no		(O.C.M.	.E.		lanuary	11,	2000
	30. Name and address of person v	no completed cause of	death (Item 23a) (T	ype, Print)		1					
1	Dennis Chute M.		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Donn	Str	at D	al+imo-	re, Mary	امد [ب	21201
0	31. Date filed (Month, Day, Year)		trar's Signature	111	Leam!	эпе	JL, D	OT L'HIMI	e, Har	TOUR	21201
State egistrar	JAN 19	2000	revenue	9 1	One	61					

Registrar



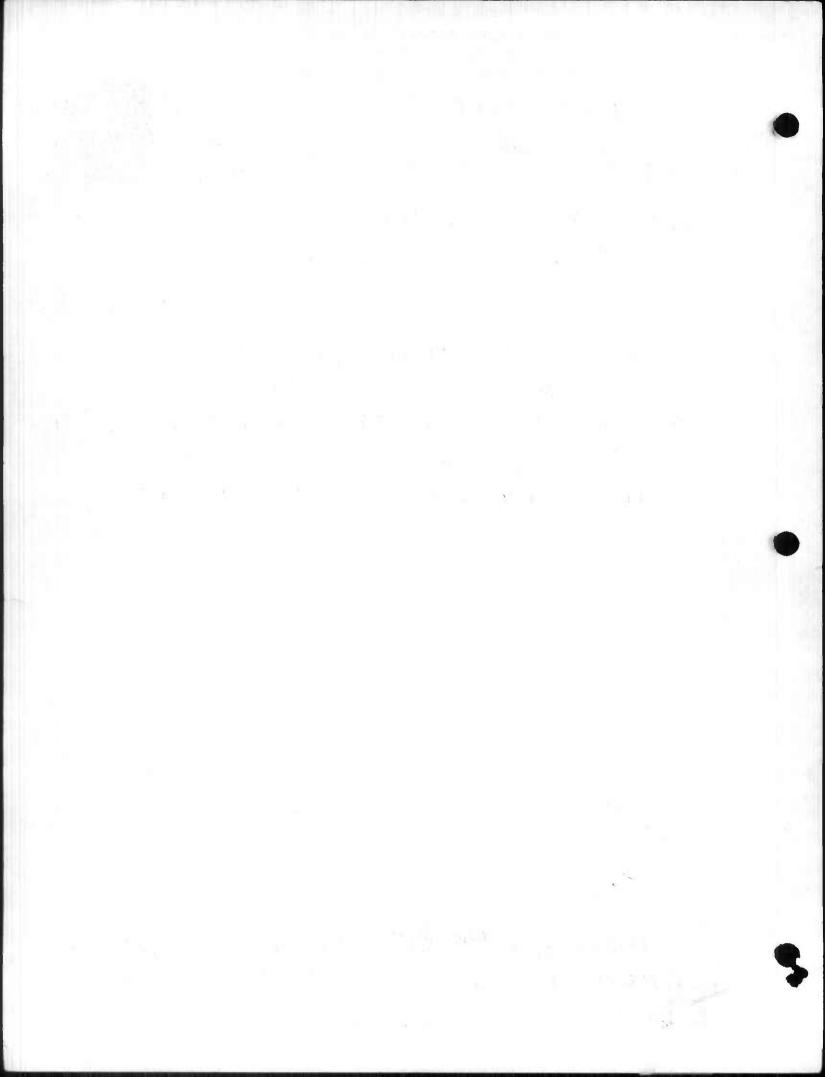
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** JONES -Month /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 219-92-033 2 6. Sex 1 M 2 □ F if Under 1 Year 7. Age (In yes, last birthday) Birthplace (State or Foreign Gountry) Months Days Hours Yrs. Director an Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 GUQUIN 112. Was Discedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Funerai 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haath and Mental Hygiena. Important: If Item 27 is marked other than "natural", or frem any injury or other traumatic evant. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□Yes 2☑No Specify: by 3 Widowed 4 Divorced Fro-Americar Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) essor 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be George 19a. Informent's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street end Number, or Rural Route Number, City or Town, State, Zip Code) 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition / Date/ 20c. Location - City or Town, 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) remator 22. Name and Address of Facility
JOSEPH
2722 W. Wor 21. Signature of Funeral Service Licansi Home uneral Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Md. 21216 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Finel ATDS y~s disease or condition resulting in death) Physician/Medical Examiner attanding physician and for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760 that initiated events resulting in death) Last Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown nellitus Drabeter by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 s 2 No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mennes of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. plataiy 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end manner stated. within 2 29b. Signature and title of certifier 136942 2000 CATURSVILLE, MD end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

URHKIIA, MD 1009, Frederick Ro

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Daath Altred Month 2600 James 0625am 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltmore Baltimore 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 € M 2 □ F Days 195-09-2115 87 Yrs. Uaual Rasidanca of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Belair 1 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 663 Red Oak Drive 21014 United States 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. 11, Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 □ Navar Married 2 □ Married 1 ☐ Yas XX No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2XXNo Specify: Specify: White 3 ☐ Widowed 4 TDivorced 15. Decedent's Education (Specify only highast greda comp 16a. Decedant's Uaual Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry completed) Elemantary/Secondery (0-12) College (1-4or 5+) 12 Computer Engineer Business Machine MFG. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Tsaac James Tena Markes 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Cary Davis / Son 663 Red Oak Drive Belari Maryland 21014 20a. Mathod of Disposition 20b. Plece of Disposition (Nema of camatary, cramatory or other pleca) 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ amoval from Stata Oaklawn Cemeetry January 17, 2000 Hanover Township, PA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licens 22. Nama and Addrass of Facility Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that chased the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List priv one cause on each line. Approximata Intervel Between Onaat and Death Immediata Cause (Finel PROGRESSIVE diagesa or condition rasulting in deeth) -AILURE Sequantially list conditions, if any, leading to Immadiata causa. Entar Undarlying Cause (Disease or Injury that Initiated events rasulting In death) Last Dua to (or as a consequanca of) 23b. Did tobacco use contributa to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown MELLITUS 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 Yas 20 No 26. Pleca of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

MD

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, important: if item 27 is merked other than "neny injury or other traumatic event. Its mental and injury or other traumatic event.

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical 3 Be Completed 10

be executed physician and s the burial-tran Box 68760. for use as P.O. | 5 signed d be del Records, page 2 this certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I

> State Registrar

29b. Signatura and title of certifiar

Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case refarred to medical 1 Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Dev Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, atraat, factory, office building, atc. (Specify) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(a) and mannar stated. Medical 29a. Certifian

D52228

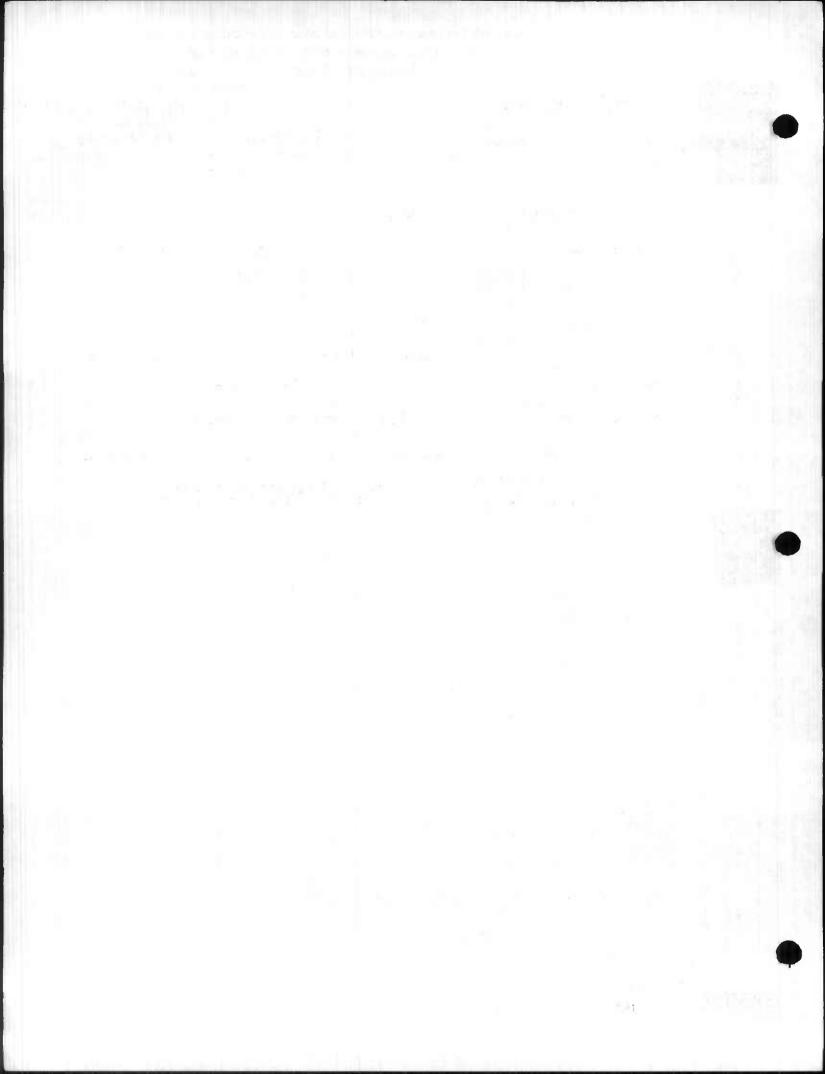
29d. Data signed (Month, Day, Year)

ss of person who completed causa of deeth (Item 23a) (Type, Print)

3007 E. NORTHERN PKWY BARTIMORE 21214 ISHALODNA MD

29c. Licansa number

32. Registrer'a Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carl, Ernest, JupitZ Month 17:25 2000 January 4c. County of Deeth Harbor Hospital Center. Baltimore N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days 1 M 2□F Months 212-09-9569 88 June 11, Wisconsin Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD N/A Yes 2□No Baltimore City 10a Street and Number 10g. Citizen of What Country? 10f. Zip Code 1414 Andre Street 21230 United States 12. Was Decedent Ever in U.S. Armed Forces?
1000/Yes 2 No
If Yes, Give
Year or Dates: 41 - 45 t 3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Raca - American Indian, 11. Marital Status Bleck, White, etc. t ☐ Never Married 2KN Married t ☐ Yes 20XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced t 6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Longshoreman Shipping 0 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Carl E. Jupitz Anna Marie Wolfe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian R. Jupitz / Wife 1414 Andre Street, Baltimore Maryland 21230 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Cedar Hill Cemetery, January Burial 2 Cremation 3 Removal from State 21, 2000 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Weeks Due to (or as a consequence of) stage disease renas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 2000 t 🗆 Yes t ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ahow

me 23a or 28a-f r must be notified

than "natural", or items 23s or the Medical Examiner, must be

Director

Funeral

þ

Completed

88

death with the Maryland

72 hours after

Hygiene.

permit. Pages 1 and 2 should be filled w Department of Heath and Mental Hygien Important: if hem 27 is marrised other tha any Injury or other two

altimore, Maryland 21215-0020

Physician/Medical à Completed 8

ettending physician for use as the burlel 2 signed t 3 certificata To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, Medical Certification: To

P.O. Box 68760, Division of Vital Records.

State Registrar 29b. Signature and title of centile Salama, mi

5 Pending

investigation

6 Could not be

29c. License number

28c. Injury at Work?

1 Yes 2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

January 17, 2000

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Hanguer Street, Baltimore, MO 21225

1 Yes 2 No

27. Manner of Death

Natural

2 Accident

4 Homicide

3 Suicide

29a, Certifier

32. Registrar's Signature

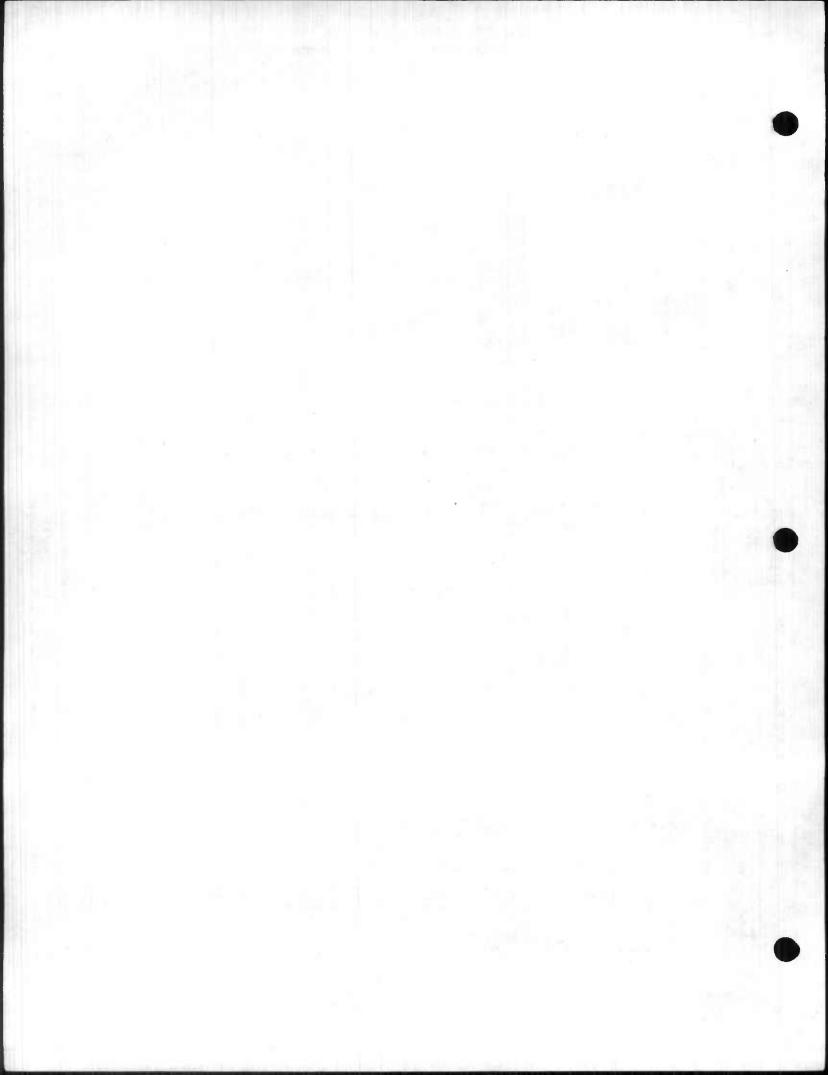
Hospital: t Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b Time of

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

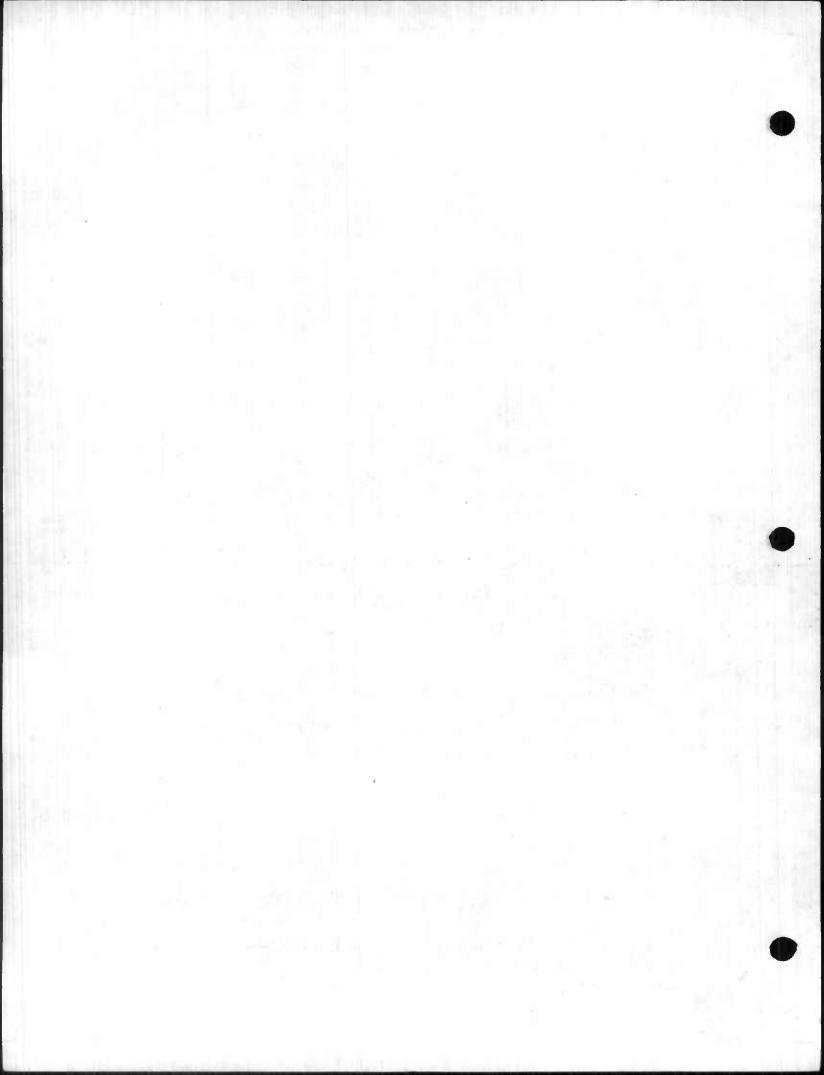
Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted.



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death		Re	ıg. No.	0 1	0 2 0		
		_	1. Decedent's Neme (First, Middla, La	st)						2. Dete of Death		V	3. Time of Death		
k	Physicia:		WILLIAM	S.	JOHNS	ON, SR				Month	Day 17	2000	2:30 P.M.		
	/Medica Examine	-	4a Facility Nama (If not institution, giv	a street end number				4b. City, To	wn, or L	ocation of Death	4c. County				
1	Examino	1	UNION MEMORIAL					BA	LTI	MORE		N/A	A		
	Funeral		5. Social Security Number 6. S		ga (In yrs. lest birti		r 1 Year			8. Date of Birth	Vonel	9. Birthp	lece (Stete or Foreign try)		
в	Director		219 12 7025	RM 2□ F	75 Y	rs. Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 01-09-19	25	Coun	VA.		
۰	D	-	Usuel Residence of Decedent					1-							
	nylar how		10a. Stete 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits		
	W T	010	MD N/A			BALTIMO	ORE						1 Yes 2 No		
	leath with the Marylan ma 23a or 28a-f show mant be notified at	Director	10a. Street and Number			10f. Z	ip Code			10	og. Citizen of	What Coun	try?		
	23a		3904 FERNHILL AVI	ENUE			21	215			J	JSA			
	72 hours after death with the Maryland natural; or Nerna 23a or 28=1 show dies Examiner must be notified at	runerai	11. Maritel Stetus	12. Wes Decedan Armed Forças	t Evar in U,S.	13. Was Dec	edent of	Hispanic Ori	gin? (Sp	ecity Yes or No- Rican, etc.)		ck, White,			
0	offe of the		1 ☐ Never Merried 2 Married	1 X Yes 2 If Yes, Give	No		-	Specify:		, , , , , ,	Specif	DI			
000	ours	2	3 Widowed 4 Divorced	Yaar or Datas	WW11			, open,			Specii				
5	natural,	Completed	15. Decedant's Ed (Specify only highast gra			Decedent's Us (Give kind of w	ork done	e durina mos	t of work	ing	16b. Kind of B	usinass/Ind	lustry		
121	filed within Hyglene. ther than ord, the Me	E	Elementery/Secondery (0-12) College (1-4or 5+)								CULTY	ODING			
7	Hygle where	3	8			LONGS	HURE	1				PING			
Ind		ď	17. Fathar's Name (First, Middle, Last,							e (First, Middle, N	faiden Sumer	ne)			
yla		0	MILTON JOHNSON					FAN	INTE	SMITH					
Maryland 21215-0020			19a. Informent's Neme/Reletionship (Type, Print)	19b.	Meiling Addras	s (Stree	et and Numb	er or Rui	ral Route Number,	City or Town	, State, Zip	Code)		
		-	GERALDINE JOHNSON	N/WIFE				LL AVE	E. B.	ALTO., MI					
Ore	8 7 2 0		20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □	Removel from Stete	cemetery	Disposition (No.), cremetory or	other pl		i		20c. Location				
E	nrit. Pagentiment ordant: Injury		4 ☐ Donation 5 ☐ Other (Specif		GARRIS	ON FOR	EST	VET.	L	/24/2000	OWINGS	5 MILI	LS, MD		
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Servica Licer	isee /	n	JAMES"	Addi	MORTON	8	SONS F.H	., INC				
Ш	20529		Vames (1. WIP	tin					ALTO., MI		17			
			23a. Part . Enter the disease, or com shock, or heart failure. List only	plicetions that cause	ed the deeth. Do n	ot antar tha mo	da of dy	ing, such es	cardiac	or respiretory arra	ist,	1	Approximate Intervel Between		
	Physician												Onset and Deeth		
	/Medical		Immediete Cause (Finel disaase or condition	Q	evere	Lland	Paci	0.0					1 20.		
г	Examiner		resulting in deeth)	e	Due to (or es e c			CY					1 day		
	asscuted in and iel-transit			. A	ossible.	Sooke	Q	bock					1 day		
	eeth certificate be assecuted strending physicien and for use as the buriel-transit	E	Sequentially list conditions,	D	Due to (or as a c			COCK				1	Tund		
o,	len a uriel-		Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or Injury									1			
68760,	ficate be physicle is the bu	Sica	that initieted events rasulting in death) Last	C	Due to (or es e co	onsequence of):					i			
39 3	ng pl	2										1			
Box	The law requires that the deeth ce tale has been signed by the attending page 2 should be detached for us.	28		d								1			
. F	he stren	2	Pert II. Other significant conditions of	ontributing to death	but not rasulting in	the underlying	cause g	iven in Pert I	i.	23b. Did to	bacco uss co	ontribute to	the cause of death?		
P.0.	of the stache		ECON	1/ 1 /-	/ / / 515 0							1 ☐ Yes 2 1 No 3 ☐ Probably 4 [
s,	law requires thet as been signed be signed by S should be detailed by D	2	ESRD on Hemoc	lialysis.	SIP COM	nary A	rten	PAPO	225						
ord	eduir ould	3								24a. Was ar		evi	ere autopsy findings allable prior to		
ec	aw n	2	gatt in Dec 1	999. DN	1 type 2	. 71						of	mpletion of cause death?		
2	The late had page	5								1 ☐ Ye	s 2 No	10	Yes 2□ No		
ita	ertifica sctor, p	0	25. Was case referred to medical					26. Place	of Deal	th (Check only on	Θ)	1			
of Vital Records,	die S	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ER/Out	patient 3 C	O AO	ther: 4 Nu	ursing Ho	ome 5 Reside	nce 6 Dot	har (Specif	y)		
0	er thi		27. Menner of Death	28a. Deta of Inj	ury 28b. T	ma of jury	28c. Inj			28d. Describe ho					
Division	or Attending after deeth. Director: After fin by the fune		1 Monturel 5 ☐ Pending investigation		oy 10a1) III	M		∃Yas 2□	No						
Vis	Attender de by th		3 Suicide 6 Could not b 4 Homicida datarminad	289. PIECE OF TE	njury - At home, far	m, street, facto	ry, office	9		28f. Location (St.		ber or Rura	I Routa Number,		
Ö	is after deeth. al Director: After ted in by the funera	5	- I romoda	building, a	itc. (Specify)					City or Town	, 31919)				
				ysicien: To the best											
	in 24 hours he Funer pletely fil	3	(Check only 2 Medical Examone)	niner: On the basis of end menner s	or axamination and teted.	or investigation	n, in my	opinion, das	ith occur	red et tha tima, da	ata end place,	and dua to	tha cause(s)		
	Withii To the Comp	-	29b. Signature end title of cartifier					nse number	0.5		9d. Deta signe				
			Jehad Laki	cis, Me)		AT	243	89.	46	Januar	1 17	, 2000		
	10	1	30. Neme and address of person who	completed cause of	deeth (Item 23e) (1	Type, Print)					11/				
	-		Jehad Lakkis		remorial +		20	1E L	niv 1	Pkway B	altimor	e, ME	> 21218		
	State		31. Dete filed (Month, Dey, Year)	32. Redist	trer's Signature	6. 1									
	Registrar		JAN 192	000	/	- 17	of the way								



Division of Vital Records,

notes or Attending Physicien: The course of the conficer of the conficer of the conficer of the conficer of the course of the co To the Hospital within 24 hours a To the Funeral C

> 0 State Registrar

edica

29a. Certifier

29b. Signature

and title of certifier

D0022633

29d. Date signed (Month, Day, Year)

Suite 2/2 Towson.

18, 2000 Jan.

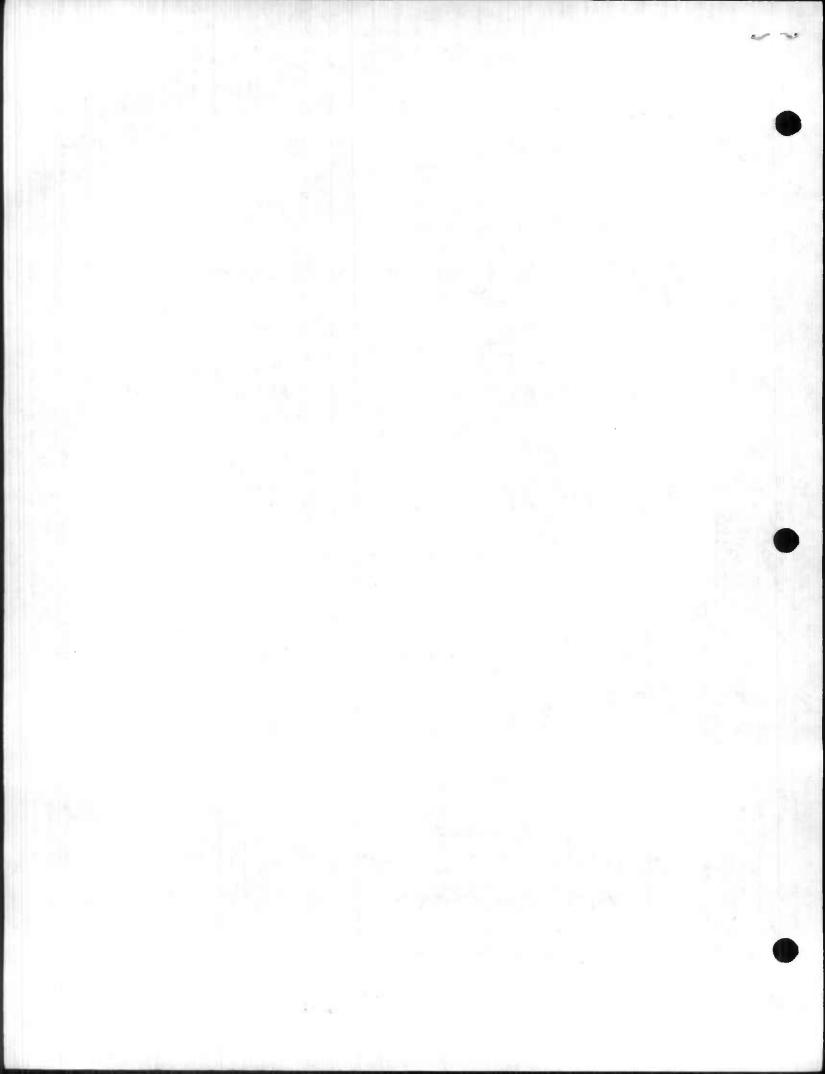
pleted cause of death (Item 23a) (Type, Print) of person who cor

> 32. Registrar's Signature 9

oaks

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

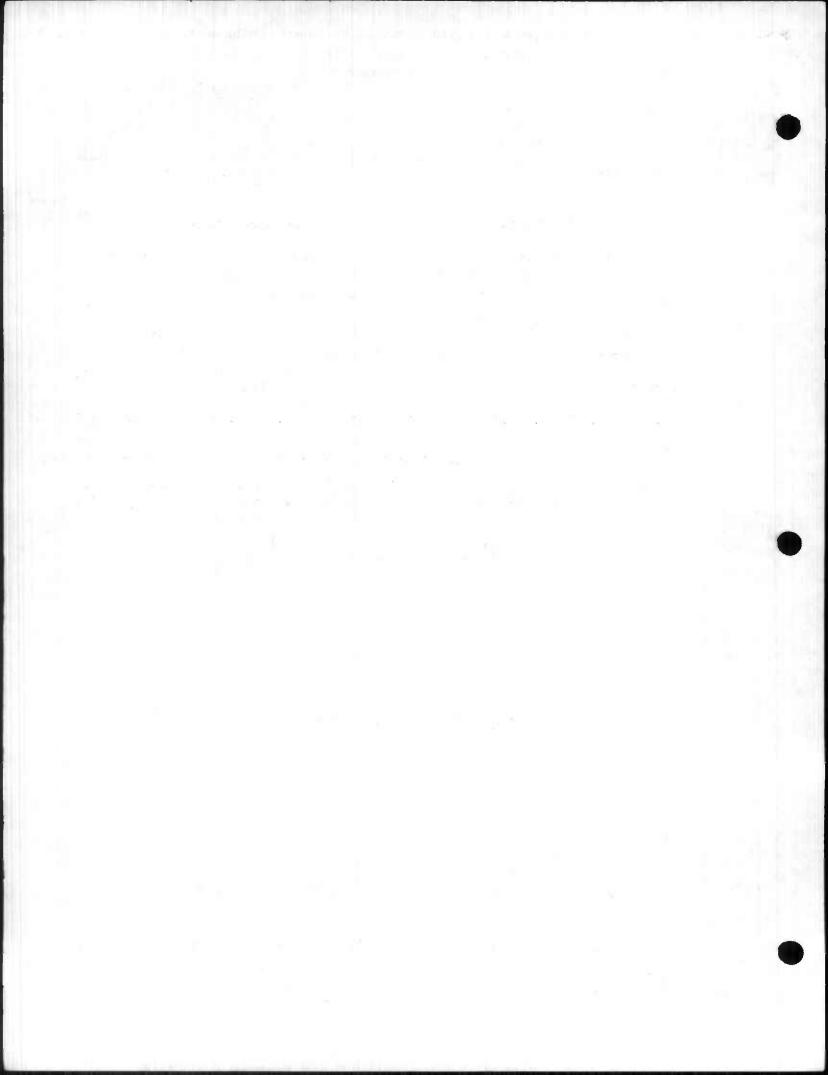
29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

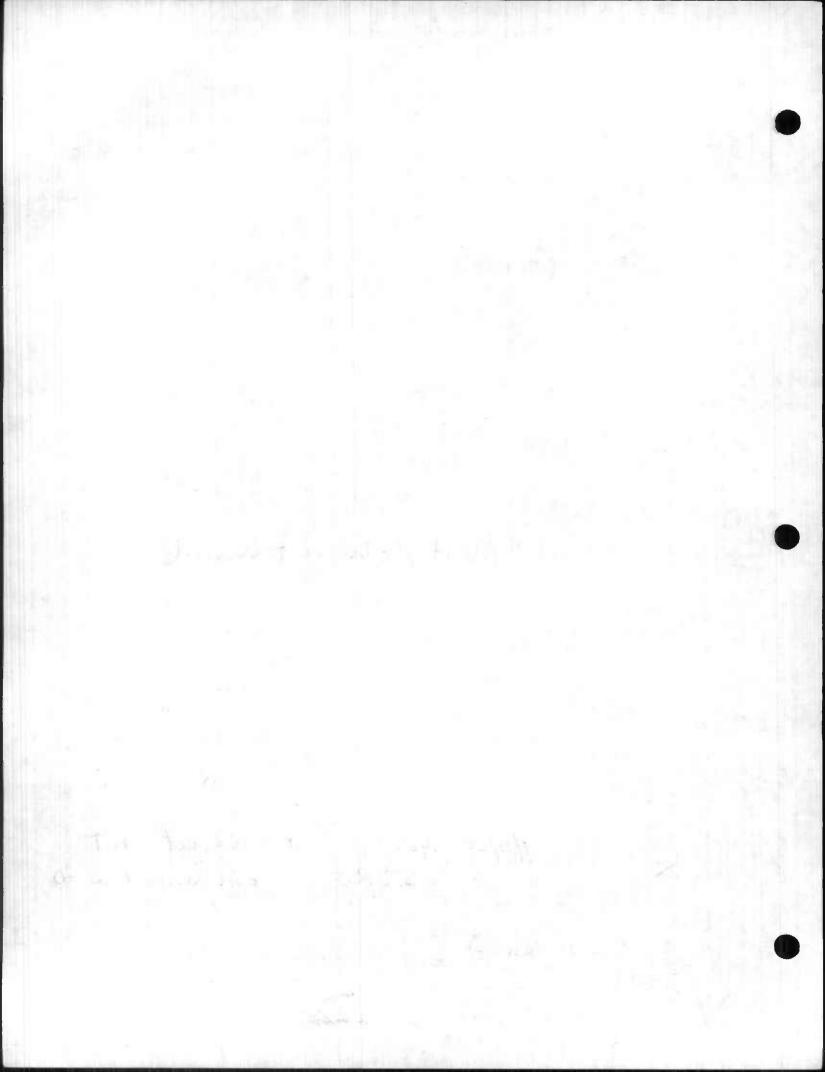
								rtificate		Death		Reg. No.	U	0109	6.
	Physic		1. Decedent's Name (First, N		1) 255G						2. Data of D Month	Diy	Year OOO	3. Time of De 7:35	
	/Medi Examir		4a. Facility Nama (If not instit	ition, giva	street and nur	nber)				b. City, Town, or				7.50	
1			Johns Hop	Kins	Geria	tric C	enter			Baltimos	re	1	N/A		
	Funeral Director	Г	5. Social Sacurity Number 215-40-5137	6. Se			s. last birthdey) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Data of B (Month, D Oct. 1	rth ay, <i>Year</i>) 3,1910	9. Birthp Coun Mary.	iace (Steta or F fry) Land	oreign
	how		Usual Residence of Deceden 10a. State 10b. Con			10c. C	city, Town or Lo	cation			1	Od. Inside City			
	Ba-f a	cto	Maryland	N,	/A					Balti	more Ci	ty		HXYas 2	□No
	19 P	Director	10e. Street and Number					10f. Zip	Code			10g. Citizen of	What Coun	try?	
	ath v	ral	4940 Easter	n Ave						21224		United			
21215-0020	be filed within 72 hours after death with the Manyland hal Hygiene. d other than "natural", or items 23s or 28s-f show event, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ □ 3 ☑ Widowed 4 □ Divor		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 XNo e		Was Deced f Yes, spec 1 ☐ Yes 2		lispanic Origin? (S an, Mexican, Puar Specify:	specify Yes or N to Rican, etc.)	Specif	ck, White,	etc.	
0	2 hor	ted	15. Dece	dent's Edu	ucation		16a. Deced	dent's Usua	Occup	ation		16b. Kind of B	16b. Kind of Business/Industry		
218	B. B. Wed	Completed	(Specify only his Elementary/Secondary (0-1		(e completed) Coilege (1	-4or 5+)	(Give	kind of wor DO NOT us	k done e retired	during most of wo	rking	Health	Care	e	
2	gient gient er th	Son	Not Known				Hous	sekeer	ping		Instit				
nd	a oth	Be	17. Fether's Neme (First, Mid	. ,						18. Mother's Na	. Mother's Name (First, Middle, Meiden Sumeme				
Z	2 should be filed within end Mental Hygiene. Is marked other than aumetic event, the Me	10	Albert Selic							Rosal	ie	(Not Ki	nown)		
, Maryland	d 2 in e		19e. Informant's Name/Relat				8810	0 Walt	ther	end Number or R Blvd.					234
Baltimore,			20a. Method of Disposition 1 th Burial 2 ☐ Cramati 4 ☐ Donation 5 ☐ Othe			Stata	Place of Dispo cematary, crer k Lawn	netory or of	her plac		Date	20c. Location Baltin		wn, Stete Maryla:	nd
Balt	permit. Pages 'Department of H Important: If Ita any Injury or of once.		21. Signature of Funeral Sen	ica Licens						ss of Facility Funeral Ave. D		f Dunda: Maryla		nc. 1222	
	_		23a. Part1. Entar the disaase shock, or heart leilure.	, or comp	ications that co	used tha da								Approximate Interval Between	
	Physician /Medical Examiner).	Immediate Cause (Final disease or condition resulting in deeth)			Pulmo	n Ary (or as a consec	Em						Onset and Des	ath
x 68760, 돈	eath certificete be executed attending physician and I for use es the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last	{	b		or as a conseq								
. Box	death e atte	icia	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ca						cause given in Part I 23b Did to			tobacco use co	ntribute to	the cause of o	death?
P.0	res that the de signed by the a be detached f	by Phys							45			Yes 2. 2 No		ebly 4□Un	
Records,	aw requi	Completed b	Dementia									s an autopsy ormed?	ava	ore autopsy find allabia prior to appletion of caus death?	
œ	The late he pege	E O									10	Yas 2 XNo	10	Yes 2 No	3
<u>ita</u>		Be (25. Was case relerred to med	ical						26. Piece of De	eth (Check only	one)			
on of Vital	Phys this ral di	2	27. Menner of Death 1 ☑Naturai 5 ☐ Pending 28a. Dete of Injury (Month, Dey Year) 28b.			28b. Time of Injury		DOA Other: 45 Jursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred					7)		
Division	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident Inv 3 Suicide 6 Co 4 Homicide del		tie. Piece of Injury - At home, larm, street, factory, office building, etc. (Specify)				281. Location (Street end Number or City or Town, State)			l Route Number	ν,		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edicai	29a. Certifier Certifier (Check only one)	iying Phys al Exami	sician: To the ner: On the ba and mann	sis of examin	owledge, death etion and/or Inv	occurred a restigation,	at the time, date and place, and due to the ceuse(s) and, in my opinion, deeth occurred at the time, dete and place			ceuse(s) and m dete and piece,	anner as st and due to	ated. the cause(s)	
	Withi Withi Comi	M	29b. Signature and titia of cer	ifier						e number		29d. Date signe			
	m		30. Name and address of bers	Em o	nd no	of death fire	m 02c) (T	D	005	53124		January	118.	2000	
	/		5505 Hope	on who co	Revision Revision	or death (ite	m 23a) (Type,	Print)	Jin	my Edi	mond m	,D			
	Sta Registr		31. Date filed (Month, Day, You	er)	32. Re	gistar's Sign	nature	91111	NOT.	e maryl	9716	1 667			



Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

JOS	SEPH KEVI	N JACKSON	State of Maryland /	Certificate of			, No.	01093				
	Physician	1. Decedent's Name (First, Middla, La	ast)	- 10 - 11		2. Date of Death Month	Day Year	3. Time of Death				
¢.	/Medical	UOSEPH	KUA	CKSON		JANUARY	11, 2000	1405 PM				
	Examiner	4a Facility Name (If not institution, give 6316 REISTERSTON			4b. City, Town, or Loc		4c. County of Death					
_			Sex 7. Age (In yrs. last	BALTIMORE If Undar 24 Hrs.		9 Righ	place (State or Foreign					
	Funeral Director		12M 2DF 39	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	GO COU	place (State or Foreign ntry)				
	yland how	10a. Stata 10b. County	10c. City, To	own or Location				10d. Inside City Limits				
	vith the Mar or 28a-f at be notified Director	MD		BALLIME	ORE			1 × 2 □ No				
	Dire	10e. Street and Number	1	10f. Zip Code	179	100	Citizen of What Cou					
	a 23 mart	1151 KITMO	12. Was Decedent Evar in U.S.		239	cify Vee or No.	14. Race - Ameri					
21215-0020	72 hours after death with the Maryland natural; or thems 23s or 28s-f show see Examiner must be notified at the Examiner must be not	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 20 Norced	Armed Forces? 1 Yas 2 Ho If Yes, Give Year or Dates:	If Yes, specify Cut	Hispanic Origin? (Spe ban, Mexican, Puerto I Specify:	dican, etc.)	Black, White,					
2-0	ed within 72 hours ygiene. or then "natural", ft, the Woulder Exi Completed by	15. Decedent's E (Specify only highast gr		Sa. Decedent's Usual Occu (Give kind of work done	during most of working	16	6b. Kind of Business/In	ndustry				
121	5 c 0	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)		CUSTODI	ML				
		17. Fathar's Nama (First, Middla, Last	*)	UHMIT	18. Mother's Name							
lan	Sags w	LEE IM	1 - 11 -	2	MAN	OY 1	4111					
Maryland	# P E E	19a. Informant's Name/Reletionship		9b. Mailing Address (Stree	et and Number or Ruge	Route Number, (City or Town, State, Zi	p Code)				
	and 2 h 27 is er trau	MARY VACKS	ON (MOTUBE)	1151 KIEM	ORE Rd	BALT	0, Md 2	1239				
ore	- f 5 5	20a. Method of Disposition		of Disposition (Name of stery, cramatory or other plants	ace)	Date 20	C. Location - City or T	own, State				
Ĕ.	Pag ment: It	4 Donation 5 Other (Speci		V6 PARI	- 1	-18-00	MI)					
Baltimore,	pemit. Departm Importal any Inju	21. Signature of Funeral Service Lice	nsee	22. Name and Addr	norE, M	00 21 0 MD 3	1207	of his HVE				
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the death. D	o not enter the mode of dy	ring, such es cardiac o	r respiratory arres	it,	Approximate tnterval Between				
6	Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting In death)	a. Due to (or as	a consequence of):	shot l	Nun	ds	Onset and Death				
	asscuted n and ial-transit Examiner	Sequentially list conditions										
0	sician and burial-transit	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying										
68760,	ficate be assected physician and is the burial-transit edical Examile	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of):										
			d									
Вох	mat the death certing of by the attending detached for use a physician/M.											
0	y the iched	Part II. Other algnificant conditions	contributing to death but not resulting	g in the underlying cause g	iven in Part I.		10	to the cause of death?				
4	5 00					1 Yes	2 2 No 3 Pro	obably 4 Unknown				
rds						24a. Was en		Vere autopsy tindings vailable prior to				
Vital Record	_ D 00 _					perioriti	0	omplation of causa I death?				
E I	me law ate has page 2					1 Yes	2 No	TYes 2□ No				
/Ita	E # 0 0	25. Wes case referred to medical examiner?			26. Place of Death	(Check only one,)					
of V	H Sign	1∭ Yes 2□ No		Outpatient 3LI DOA			ce 6 Nother (Spec	(b) AT SCENE				
	tal or Attanding Programmers at Director: After to led in by the funeration:	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	D. Time of linjury Wo		28d. Describe how	injury accurred	-1-				
Division	Artanding or death. ector: After by the fune iffication	2 Accident investigation 3 Suicide 6 Could not be	DO CONTRIBUTION ALL DO	900	Yes 2/7No	28t. Location (Stre	et and Number or Rui	ral Route Number				
5	after death Director: d in by the	Homicide determined	building, etc. (Specify)	STARIZ	-	City or Town.	et and Number or Rui State)	Ro				
	Funeral letely filled		hyalcian: To the best of my knowled									
	to the hospital or Attending Within 24 hours after death. To the Funeral Director. After completely filled in by the funeral Medical Certification	(Check only 27) Medical Example (Check only one)	miner: On the basis of examination and manner steted.	and/or investigetion, in my	opinion, death occurre	ed at the time, det	e end placa, and due	to the cause(s)				
	within 2 To the comple	29b. Signature and title of certifiar	0 0		nse number		d. Date signed (Month					
	m	1 Conte	rte and		CME		JANUARY 12	, 2000				
	1	30 Nama and address of person who	completed cause of death (Item 23									
-	Chris	31. Data filed (Month, Day, Year)	32. Registrar's Signatura	enn Street, E	Baltimore,	Maryland	21201					
	State		222		4							



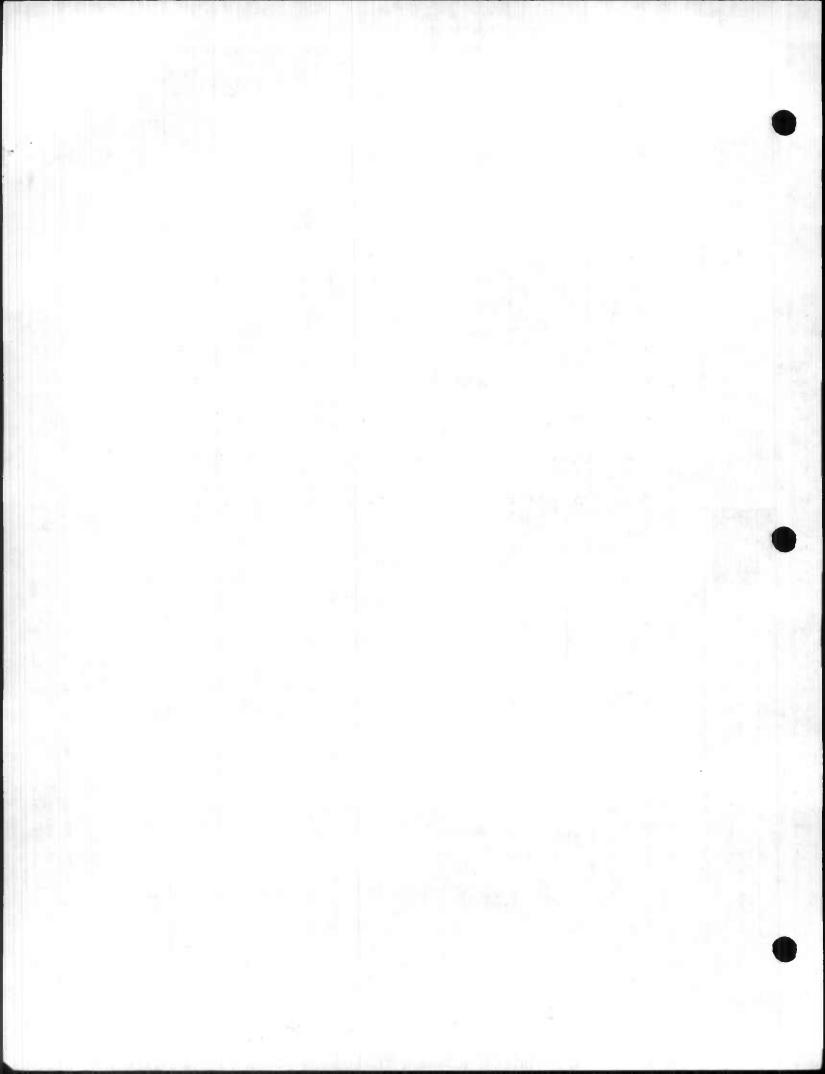
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jagodzinski Paul A 0415 Jan 15 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Towson Gilcrest Hospice Hours Min. 8. Date of Birth (Month, Pay, June 11, 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days 10XM 20 F Mary Land 219-18-7957 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Baltimore 28a-f MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 United States 21286 23a 8618 Drumwood Dr. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Dry Cleaning Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Jagodzinski Serba Helen August 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21286 Janice V. Jagodzinski 8618 Drumwood Rd or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 1-17-00 Beltsville, MD Chesapeake Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Fecility 21. Signature of Funeral Service Licenses CAFA Stephen D. Lohmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** yngeal CAncer Immediate Cause (Finat disease or condition resulting in death) /Medical ems Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Peul Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 1XYas 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? certificata 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICO Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending death. 1 Yes 2 No Investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 25205 15,2000 no Name and address of person who completed cause of deeth (Item 23a) (Type, Print) GAMC N. Charles St. Balto md 6701 32. Registrar's Signeture State 9 2000 Sparks Registrar

ORIGINAL

00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death MINNIE -DHNSON 9.08 Am AN. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Yaar Months Deys If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 76 Yrs. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 214-22-1315 1 □ M 200(F March 13, 1923 Md. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5616 Tricross Drive 21045 USA 13. Was Decedent of Hispanic Origin? (Specify Yaa or No-if Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 12. Was Decedent Evar in U.S. Armed Forces? 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 Yaa 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 □XINo Specify: Black. 3 Divorced 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) Housewife Self Employed 8th Grade 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Samuel Blackstone Florence Adams 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Gail Thornton Daughter 508 Crosby Road Baltimore, Md. 21228 20b. Place of Disposition (Nema of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1) Surial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Elkridge C.C. Church Cemetery Jan. 18 Elkridge, Md. 22. Nama and Addrass of Facility Nutter Funeral Homes, 21. Signatura of Funaral Sarvice Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 heit を. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediata Causa (Final disaesa or condition rasulting in deeth) Due to (or as a consequence of): 6 months Sequantially list conditions, if any, laeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? NA 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings 24a. Was an autopsy

Physician /Medical Examiner

permit. Pages 1 end Department of Health Important: if item 27 any Injury or other tr once.

Physician

/Medical

Examiner

Md.

Director

Funeral

p

Completed

Be

Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Hestical Examinar must be notified at

Pages 1 and 2 should be filled within 72 hours efter death with it ent of Heatih and Mental Hygiene.

nt: if item 27 is marked other than "natural", or itema 23a or i

Baitimore, Maryland 21215-0020

the Maryland

physician and s the burial-transit The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: this

Examine Physician/Medicai py Completed Be Medical Certification: To death. 24 hours after deat Funeral Director: filled in by

_				performed?	available prior to completion of ceuse of death?						
				1 ☐ Yes 2 No	1 ☐ Yas 2 ☐ No						
25	. Was casa ratarred to medical	26. Placa of Deeth (Check only ona)									
	axa <i>m</i> inar? 1 ☐ Yes 2丛No	Hospitel: 1 Inpatient 2 ER/Outpatient 3	fome 5 ☐ Rasidence 8 ☐ Othar (Specify)								
27	. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidant invastigeti		28c. Injury at Work? 1 Yas 2 No	28d. Dascribe how injury occurred							
	3 Suicide 6 Could not determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29	la. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurre miner: On the basis of axamination and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and dua to tha cause(s) and man arred at the time, date end piece, an	ner as stated. Indidue to the cause(s)						

Registrar

completely within 2 the th

31. Data filed (Month

29b. Signatura and titla of certifian

29c. Licansa number

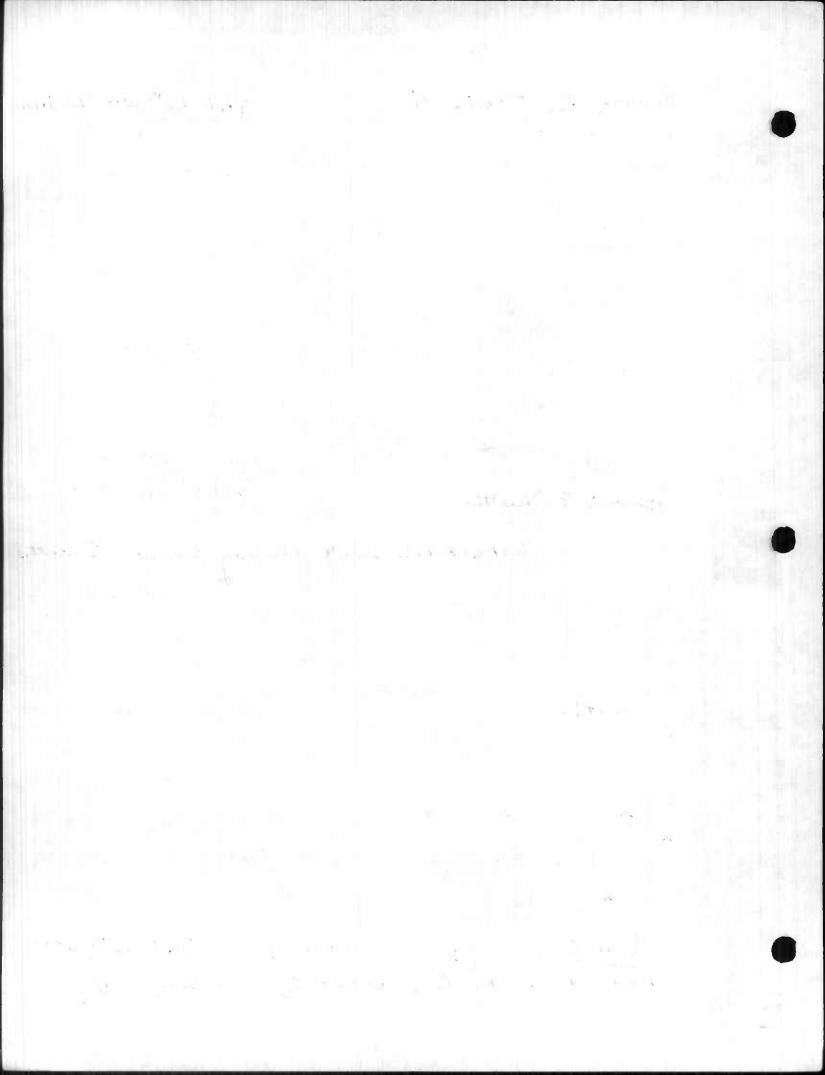
29d. Data signed (Month, Day, Year) 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Howard

Day, Year) N 1 9 2000

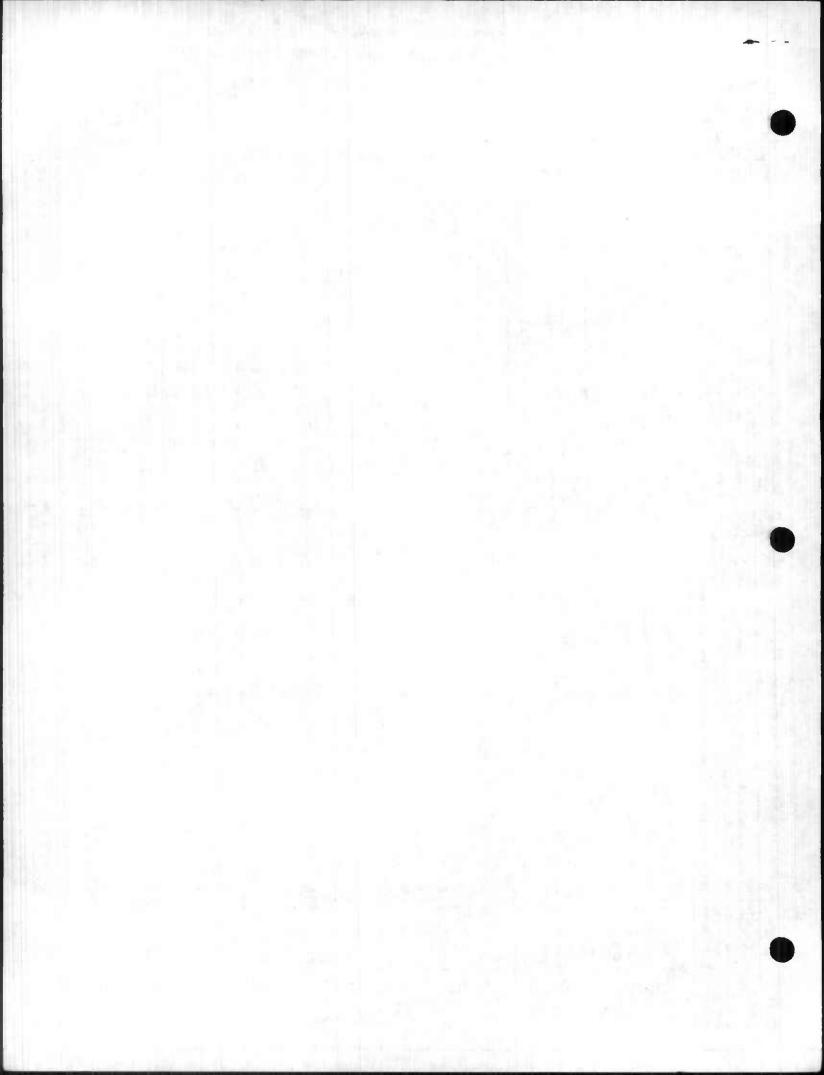
32. Registrar's Signatura



Willam Theodore Keefer Please Type or Print In Black Indelible Ink. Assure All Copies Are Lealble.

of Frint in black indelible lisk. Assure All Copies	Ale Legible.	
e of Maryland / Department of Health and Mental Hy	giene U U U 9	
Cartificate of Death		

		Certificate of Death			g. No.	0					
Dhualai		1. Decedent's Nama (First, Middle, Last)		2. Date of Death Month Day Ye		Year	3. Time of Death				
Physicia /Medic	_	William I. Keeter	Ja	nuary	12 2	2000	10:08 A.M.				
Examin			own, or Location	of Death	4c. County						
			Essex	ate of Dieth		timor					
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthdey) 6. Sex 1 Yrs. Hunder 1 Year Hunder 1 Wanth Days Hours	Min.	ate of Birth fonth, Day,	Year) 5, 1915	Cour	place (State or Foreign (17)) York				
in the Maryland or 28e-f show as notified at	ctor	10a. State 10b. County 10c. City, Town or Location Parkville				1	0d. fnside City Limits 1 ☐ Yas 2 K No				
8 23 B	ral Director	10e. Street and Number 10f. Zip Code 2123	4		g. Citizen of V	What Cour	itry?				
21215-0020 d within 72 hours after des plane. t the Medical Examiner in	by Funeral	11. Marital Status 1 Never Married 2 Married 3 War Decelers Ever in U.S. 1 Never Married 2 Married 1 Yes Give Yaar or Dates: 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 Yes 2 No Specify:		es or No- , etc.)		ck, White,	ean Indian, etc.				
72 harb	Completed	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mos	st of working	1	6b. Kind of B	Q 1	dustry				
121	фш	Elementary/Secondery (0-12) College (1-4or 5+)		1	PRIFE	DRU	MILES				
8 5 8 4		17. Father's Nama (First, Middle, Last) 18. Moths	er's Name (Firs	t, Middle, M	aiden Suman	10)					
land id be file ental Hy ked oth ic event	To Be	Doter Vander	0/11/80	BI	IPAIS						
Mary d 2 shou h and M 7 is mar traumat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Numb	per or Rural Rou	te Number,	City or Town.	State, Zip	Code)				
M sales		Blocke Leefel SON 2920 Willow	19hby	Rd.	Bala	MOF	21 Md 2123				
Pages 1. sent of His net. If New ry or oth		20a. Method Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	O Del	10 16 2	Oc. Location -	City or To	wn, State				
Pag mont ant: It		4 Donalion 5 Other (Specify) EVANS Funckal Chasel - Be	Jair 20	00 F	ORIS	I He	ll Md.				
Salt spart sport sy in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ity Evan	& Fu	nefal	Ch	apal				
m gorsa		XPASYA J. USULS 8800 Hacke	d Rd. 1	Balt	imore	Mo	1 21234				
		23a. Pari1. Enler the disease, or complications that caused the death. Do not anter the mode of dying, such as shock, or heart feilure. List only one cause on each line.	s cardiac or resp	piretory arres	st,		Approximete Interval Between				
Physician		Onset and Death									
/Medical Examiner		Immediate Causa (Final disassa or condition a. MULTIPE FMS USUSS resulting in death)				1					
	20	Due to (or as a consequence of):				1					
nsit ned	Examiner	b				-					
68760, ifficate be executed g physicien and es the bunal-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c.										
68760, ificate be ex		that initiated events									
10 2 0 0	edical	resulting in death) Last				i					
Box 6 eath certif	3	d									
. 0 0 0	Physician/M	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1.	23b. Did tob	acco use co	ntribute to	o the cause of death?				
ords, P.O.	Phys			1 🗆 Ye	2 19 No	3 Pro	bably 4 Unknown				
S the se the pe de	by										
Records, ne law requires to a hes been signe age 2 should be	Completed		2	4a. Was an perform		sv	ere autopsy findings allable prior to				
2 8 8 CD	ple			/		of	empletion of causa death?				
	FOC			1 Yes	s 2 No	14	Yes 2 No				
f Vital Repartment yelden: The law	Be	examiner?	e of Death (Che	eck only one)						
G 5 7 -	2	1 XYas 2 No Hospital: 1 □ Inpatient 2X ER/Outpatient 3 □ DOA Other: 4 □ No	ursing Home								
E & § §	Certification:	27. Manner of Death 1 platurel 5 Pending 28a. Date of fnjury 28b. Time of Injury at Work?	1 -				TH. A CAR				
Division or Attending I after death. Director: After I in by the funet	cat	2 Accident invastigation - 2 - 00 0:10 M 1 Yes 2 D	1 2	_			waisw				
or Al	ŧ	4 Homicide determined determined building, etc. (Specify)		A		oer or Huri	al Routa Number,				
Political de la company de la		29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date an		- 1 - 1 - 0	MAD	13/20	Morron				
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	ath occurred et	the time, da	te and place,	and due to	o the cause(s)				
of the of the orthograph	Me	29b. Signalum and title of certifier 29c. License number		29	d. Date signe	d (Month,	Dey, Year)				
- 5 - 0		Manute Mr. Will O.C.M.E.			Januar	77 12	2000				
1	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	•		Juliual	.у 13	, 2000				
1.		MARYD2173 A KORW 111 Penn Street,	, Baltin	nore,	Maryla	and 2	1201				
Sta	е	31. Date filed (Morth, Dey, Year) 32. Registrar's Signature									
Registra	-	JAN 1 9 2000 Senera & Sports									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** HARRY KIPPERMAN 15, 2000 JANUARY 10:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2□ F Months 077-24-6021 70 Director NOV. 19, Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location must be notified at 10d. Inside City Limits MD N/A BALTIMORE 1X Yes 2 □ No Director 95 10s Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 PARK HEIGHTS AVENUE #109 21215 U.S.A. Funeral Нета: 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Datas: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 WHITE 'natural', or 1 Yes 2 No Specify: ARMY Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) ent of Health and Mental Hyglen
It: If Item 27 Is marked other th. SUPERINTENDANT APPLIANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 8 Pages 1 and 2 should be SAMUEL KIPPERMAN FANNIE HERKOVITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN KIPPERMAN / SON 201 SINGLETREE COURT - WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. BALTIMORE HEBREW CEMETERY 1/18/2000 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ettending physicien and for use as the burist-transit pue . Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 JAN 3 Probably 4 Unknown Records, þ requires been si Completed 24a. Was an autopsy performed? 4b. Were autopsy tindings available prior to completion of cause of death? page 2 s The certificate 1 Yes 213/40 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certificaties with filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Seath (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpetient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DiNatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Funeral Dir completely filled in • Funeral 29a, Cartifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ş 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) nvaly ause of death (Item 23a) (Type, Print) opelan 32. Registrar's Signature

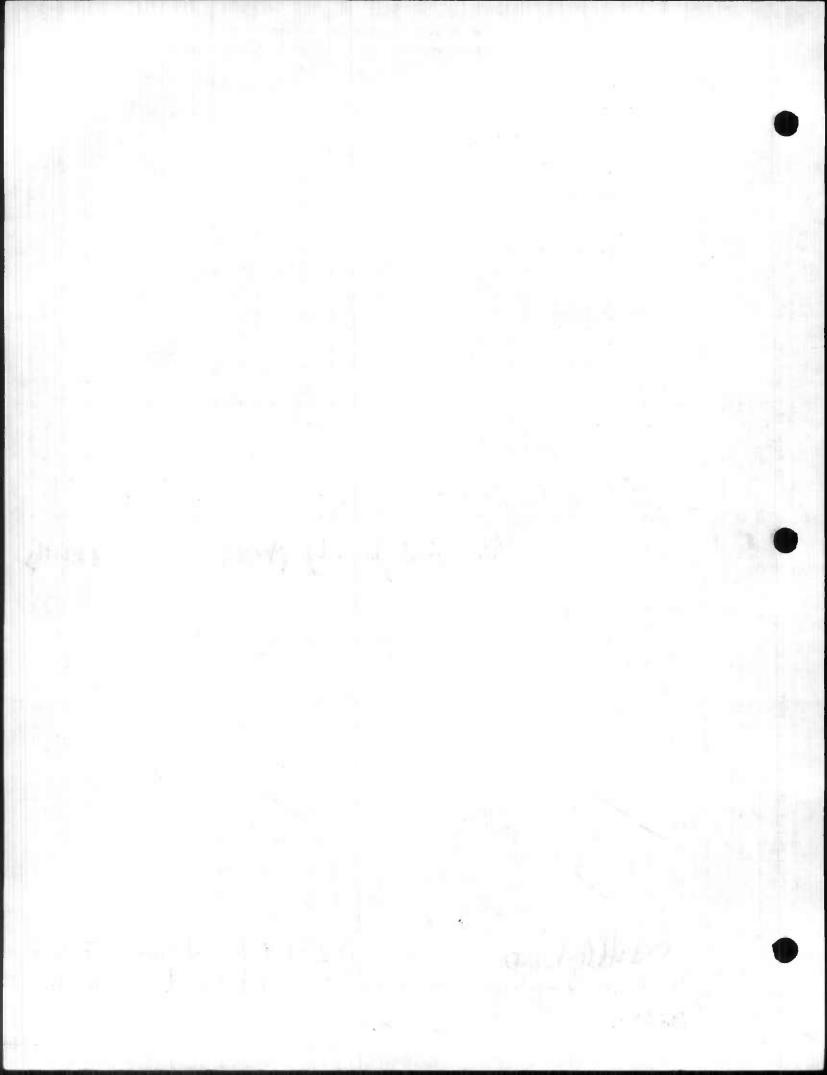
DHMH 16 Rev 6/95

State

Registrar

9

ORIGINAL



Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** January 14, 2000 3:47 PM Annaetta Marie Kraft /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12/18/1916 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Days Months Hours 1 ☐ M 2 ☑ F Maryland 216-28-9478 83 Director Usuat Residence of Decedent the Manyland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at Fallston Harford Director 1 Yes 2 TNo 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 21047 U.S.A. P.o. Box 12 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? a filed within 72 hours after de il Hygiens. other than "natural", or ham 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security permit. Pages 1 and 2 should be illed with Department of Health and Mental Hygien. Important: if Item 27 is married other traumetts arrest in Item 27 is married other traumetts. Claims Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 Margurette Josephine Blessing Walter Joseph Tress Jr. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Crouse / Daughter P.O. Box 12 Fallston, Maryland 21047 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery 1/18/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 22206 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final tage disease or condition resulting in death) M Examiner hero Sc Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, by 24b. Were autopsy lindings available prior to completion of cause of death? been s Completed 24a. Was an eutopsy performed? page 2 s 1 Yes 1 Yes 2010 cartifloata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartiflor complately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) / (15/5) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No edicai Certification: To 27. Mapner of Death 28d. Describe how injury occurred 26a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number anny. January Ramesh Sabapath Suite 30 8

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

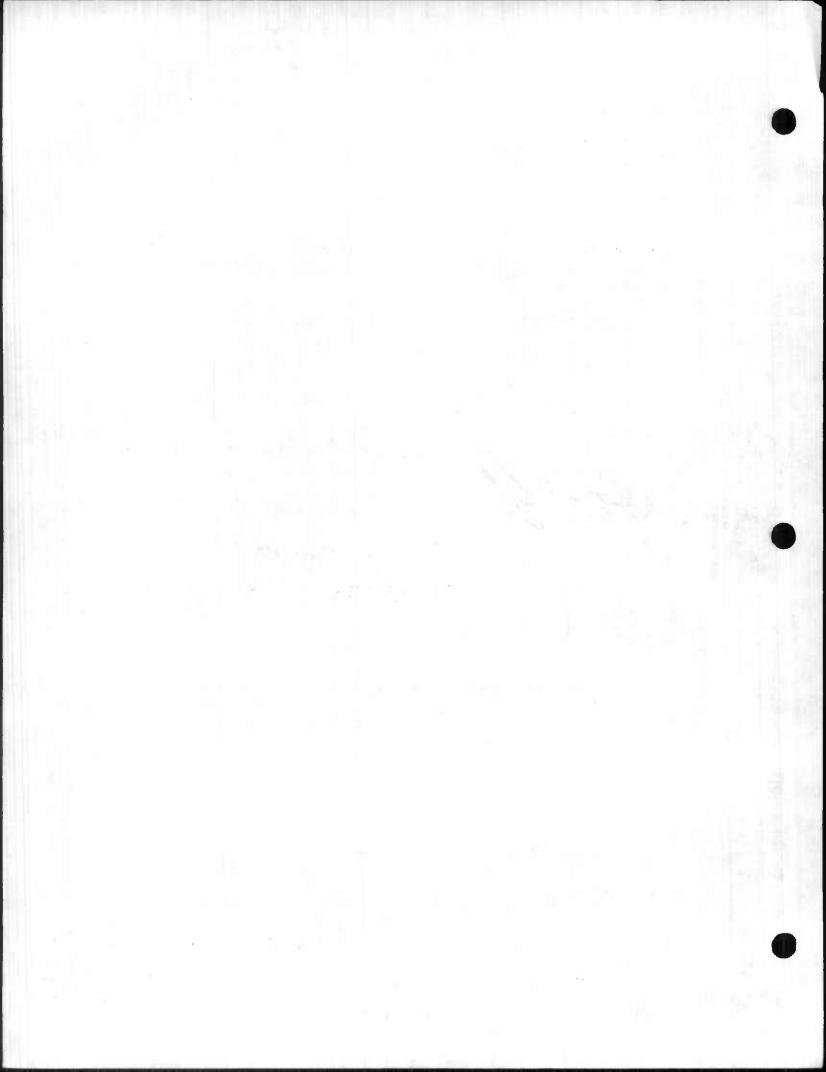
JAN 1 9 2000

oaks

32. Registrar's Signature

N. Eutaw St.

MD21201.



1. Decedent's Name (First, Middle, Last)

ranklin.

214-03-2144

Usual Residence of Decedent

5. Social Security Number

Michael Herbert Keiser

) gruare

10M 20F

ospital (

84

7. Age (In yrs. last birthday)

4a Facility Name (If not institution, give street and number)

10b. County

Physician

/Medical

Examiner

Funeral

Director

the Maryland

DHMH 16 Rev 6/95

	ylen Mari	10a. State	10b. County		10c. City, To	vn or Location						10d. Inside City Limit	
11215-0020 within 72 hours after death with the Manyland	Mar	MD	N/A	Baltimore			2					1À Yes 2□N	
	or 28	MD 10e. Street and 5811 M		0.		10f.	Zip Code			10g. Citizen of What Country?			
	23a	2811 W	oores Run	Ct.			2120	06		U.S	.A.		
	n 72 hours after deeth with the Marylen *natural*, or fema 23e or 28e-f show entre Examiner mant be notified at		us Merried 2 Married ad 4 □ Divorced	Armed Forces?	Armed Forces? 1 ☐ Yes 220 No If Yes, Give		cedent of H pecify Cubi 2 DKNo	lispanic Origin? (an, Mexican, Pua Specify:	Specify Yes or No rto Rican, etc.)	14. Race - American Indien, Black, White, etc. Specify: White		, etc.	
21215-0020	2 hou		15. Decedent's E		160	. Decedent's U			- dila a	16b. Kind of B	usiness/Ir	ndustry	
21	ithin 7		Specify only highest gra Secondary (0-12)	College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired)			orking				
	filled w thygler ther th	17 Femare No.	me (First, Middle, Last,	1		arpente	r	40 84-45	Time Middle	Ship			
Maryland	s 1 and 2 should be filled within Health and Mental Hyglena. Item 27 is marked other than other treumatic event, the Mil	Herbe	rt Keiser		Marie Kra					rst, Middle, Maiden Sumeme) Aemer			
Jar	2 sho	19a. Informent	's Neme/Relationship (19				Rural Route Numb				
	l and lealth m 27 ther tr		s Keiser/W:	ife	20h Place	5811 Mo	ores	Run Ct.	Baltimo	re, Mary	land	21206	
Baitimore,	Pages nent of h int: If its		2 Cremation 3		cemete	ery, crematory of	or other plea			20c. Location			
	it. Pr		on 5 Other (Specif	-1	Falk	wood Ce		on of English				Maryland	
n n	permit. Pages Department of Important: If it eny injury or o	21. Signature 0	010	/10					John C. 1			1500	
		23a, Part1, Ent	ter the disease, or com	plip thoris that caused the	he death. Do				Baltimor		and	21206 Approximete	
4	Physician	shock, or	heart failure. List only	cause on each line								Interval Between Onsat and Death	
	/Medical	tmmediete Cau		6/50	2:50	Linn	Pna	12.01.02	nia		į	72 hours	
١.	Examiner	resulting in dea	ith)	aD	ue to (or es s	consequence	of):	301110	That			1 1000	
	2 =			b							i		
. BOX 58/50, death cartificate be assecuted	and al-tran	Sequentially list conditions, If any, leading to immediate											
Box 68760,	asth cartificate be associted attending physician and for use as the buriel-transit	Cause, Enter U Cause (Disease that initiated ev	cause. Enter Underlying Cause (Disease or injury c.										
9	g phy	resulting in dea	resulting in death) Last Due to (or as a consequence of):										
ŏ	endin r use			d							1		
	the att	Pert II. Other sig	gnificant conditions o	ontributing to death but	not resulting	in the underlyin	g cause giv	ren in Pert I.	23b. Dld	tobacco usa co	ntributs 1	to the cause of death	
0	The law requires that the death cardificate be associted atta has been signed by the attending physician and page 2 should be detached for use as the burish-transit								10	Y98 2 No	3 Pro	bebly 4 Unknow	
Hecords,	requires that								24a. Wes	en eutopsy	24b. W	Vere autopsy findings	
င္ပ	been si bhould								perf	omed?	C	vailable prior to ompletion of cause f death?	
	an: The law tificate has b tor, page 2 s								10	Yes 2 No		☐ Yes 2☐ No	
<u>a</u>	£ 5,	25. Was case n	eferred to medical					26. Place of De	seth (Check only			2.00	
2 20	Physician: this cardificant rai director,	examiner?	No No	Hospital: 1 Quipatient	2 □ ER/O	utpatient 3	DOA Oth	ner: 4 Nursing	Home 5 ☐ Res	dence 6 Oth	ner (Speci	ify)	
	D 50		5 Pending	28a. Date of Injury (Month, Day)	Year) 28b.	Tima of Injury M	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how injury occur	rred		
JIVISION	rs after death. al Director: After ted in by the funer	3 ☐ Suicide 4 ☐ Homici		28e. Place of Injury building, etc.						ocation (Street and Number or Rural Route Number, ity or Town, State)			
- 6	ne Hospital or Attandin n 2+ hours after death. In Funeral Director: Af perally filled in by the fu	29a. Certifier (Check only	1 Certifying Ph	ysician: To the best of e	xaminetion a	e, deeth occurre	ed et the tir	ne, dete end plea	e, end due to the curred at the time,	ceuse(s) and m date end place,	anner es	stated. to the ceuse(s)	
	within 2 To the comple		and title of certifier	and manner stete	id.		29c. Licens	e number		29d. Dete signe	ed (Month	. Dav. Year)	
•	6444	> //	6				1)2		8	-			
		30 Namedand	ddress of person who	completed cause of dea	th (Item 23a)	(Type, Prints)	10	1009	0	Janua	chli	3, 2000	
	2	(man, Ho	ward I	BAI	M.D. 90	200 Fr	anklin Sa	vare Driv	e Baltin	ore	5,2000 MD2R3	
	State	31. Date filed (A	Month, Day, Year)	32. Registrer	s Signeture	1		. 0			1		
	Registrar	JA	N 1 9 2000	Der	10	Life	rest						

ORIGINAL

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death

If Under 1 Yaar

Months Days

enter

2. Date of Death

8. Date of Birth (Month, Day, Year) 11/30/1915

4b City, Town, or Location of Death

Danuary 15,2000 Lation of Death

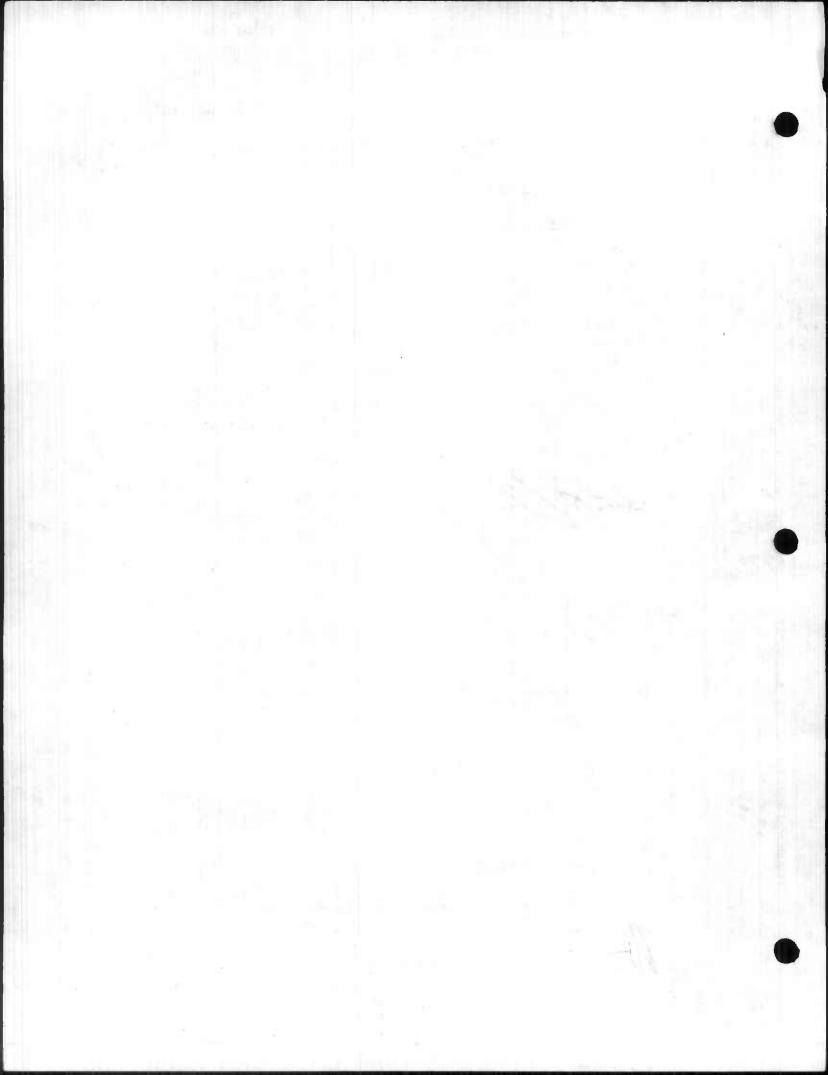
3. Time of Death

timore

9. Birthplace (State or Foreign Country) Maryland

Yes 2□No

9:30 Pm



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** MAF LEE 15 07, 2000 4c. County of Death JA-N /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) **Examiner** AGNES NURSING & REHAB, CENTER ELLICOTT HOWARD CIT 7. Age (In yrs. last birthdey) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Months Days 227-44-4796 Yrs. Director Usual Residence of Decedent tha Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 234 410 KEB USA Funeral filed within 72 hours after death Hems 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 natural, or 1□ Yes 2KNo Specify þ 3 ☐ Widowed 4 ☐ Divorced ACK Completed 15. Decedent's Educetion (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 +HGRADE permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the eny injury or other traumatic event, the brice. WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rown HENR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TER) 4/0 8 ROKEBY 20b. Place of Disposition (Name of cemetery, cremetory or other place) BALTIMORE, MD. 21229
Date 20c. Location City or Town, State KOAD VANESSA HASKINS (DAUGHTER) Saltimore, Date 20a. Method of Disposition Bunal 2 Cremation 3 Removal from State STERN STAR CEMETERIOI-13-00 CATONSVILLE, HD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funerat Service Licenses FULTON AVE 2140 N BALTIMORE, HO. 21217 Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ECUBIT MAPL The law requires that the death certificete be executed Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Due to (or as a consequence of): P.O. Part II. Other afgnificant conditions contributing to deat/Pput not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown signed by λq Division of Vital Records. 24b. Wera autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy parformed? within 24 hours after death.

To the Funeral Director: After this certificate has been a completely filled in by the funeral director, paga 2 should 1 Yes 2 DNO 1 Yas 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: Injury at Work? 5 Pending Investigation 1. Natural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

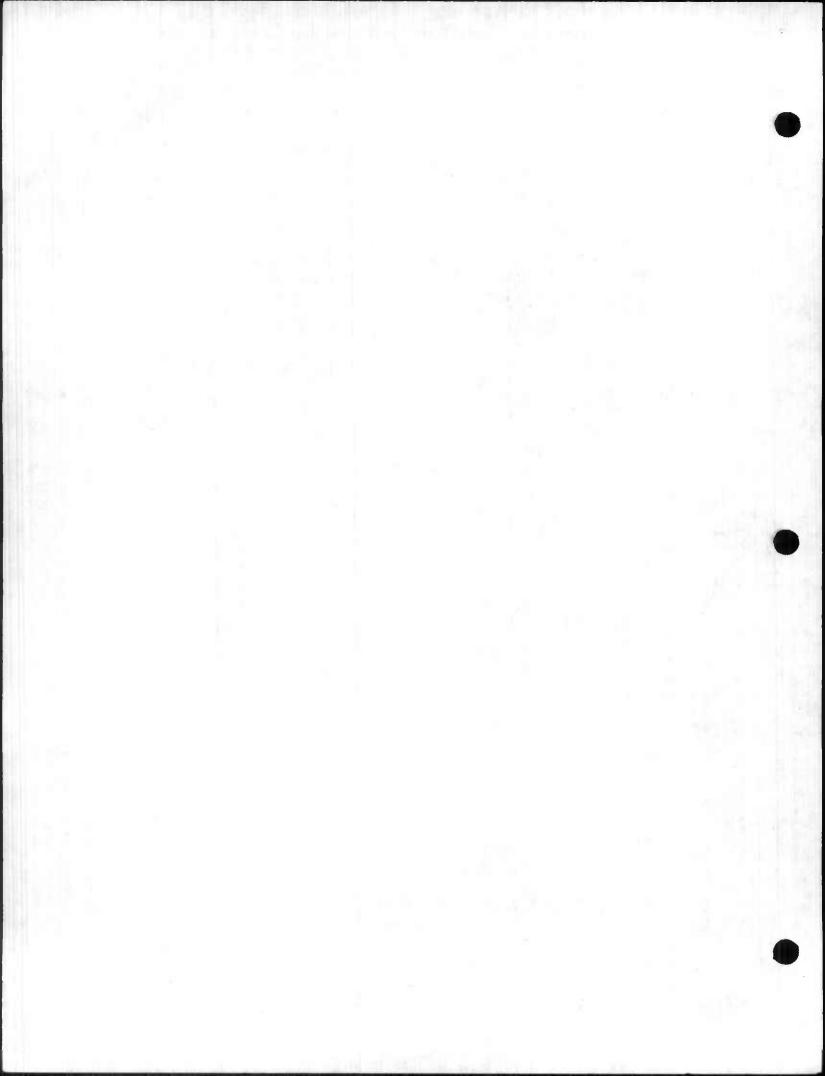
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 201 & neel 30. Nama and address of parson who completed ceuse of deeth (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State Regist<u>rar</u>

かしてかん

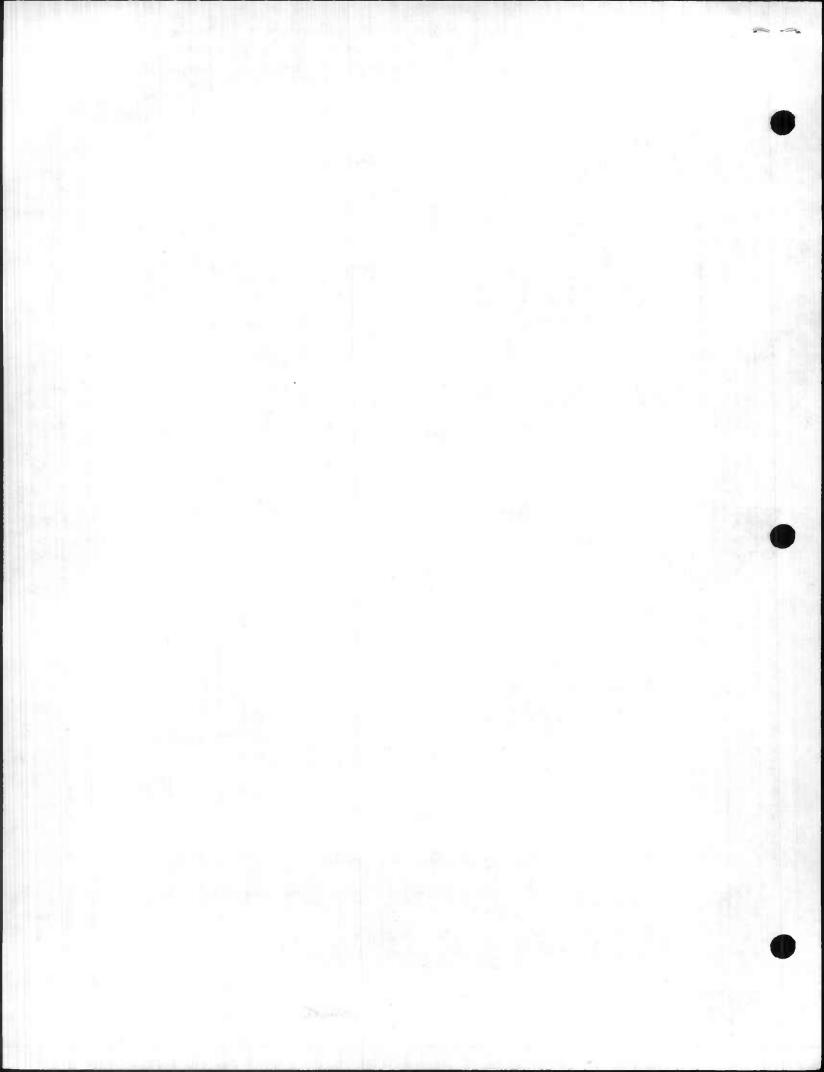
32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Yes **Physician** Lee Lotterer Barbara JANUARY 17 2000 11:30 A. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Funeral Min. Days Hours Months 20-34-571 220-34-311 Usuel Residence of Decedent Director 0 Nov. 11,1938 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? edwood 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White Saltimore, Maryland 21215-002 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 May Robinson trederick Benson Alma 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Pown, State, Zip Code) Redwood ottere Raltimore, MD21234 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Stete Jan-20 Baltimore, mD Johns Lutheras 2000 22. Name end Address of Facility Evans Funeral Chapel 21. Signature of Funerel Service Licensee 8800 Harford Rd-Baltimore, mD rantos 2123 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last dependent diabetes mellitus Box 68760, on-Insulin Physician/Medical Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Yes 2□ No 3□ Probably 4□ Unknown Railure, perpheral vasculardes Records, 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? heart failure, artenoschirotic podiovascular disease, nephaplithiasis 1 Yes 2 No 1 Yes 20(No hronic obstructive Dulmonard Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Medical Certification: 5 Pending investigation Netural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homleide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signeture and the of cartiful 29c. License number 29d. Date signed (Month, Day, Year) (ZIM) (Type, Print) mpleted cause of death (iter Balhmore oolmo N. Charles Suite 3901 6701 31. Date filed (Month) Pax. 32. Registrar's Signeture State 9 Jeneva Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

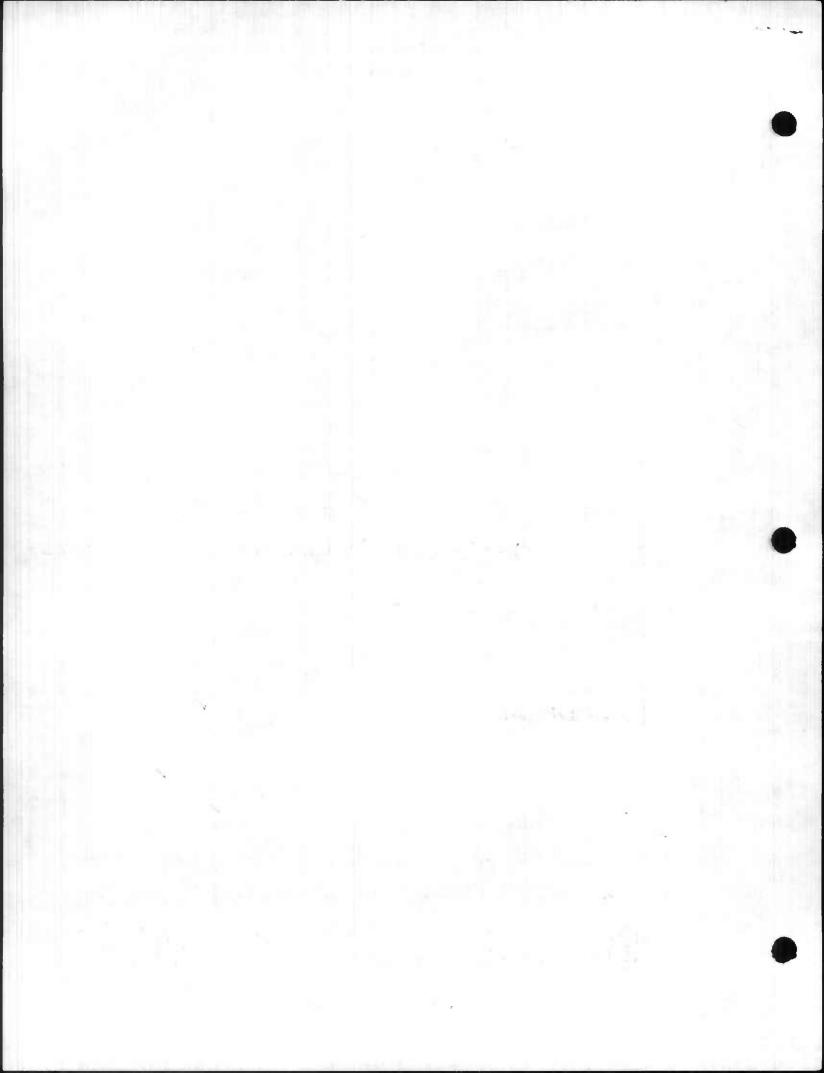


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Nama (First, Middle, Last) 2. Dete of Death Month **Physician** Margaret 91NIa an /Medical 4a Facility Name Iff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 Baltimor astridge MONIUM
HUnder 24 Hrs. 8. D.
Hours Min. H Under 1 Ves 8. Dete of Birth (Month, Day, Year) March 25,1920 5. Social Security Number 9. Birthplaca (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X F 038-05 Yrs Director Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location ehow or 28a-f show 1 Yes 2 No Funeral Director IMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? master. 210 Nema 2 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 11. Meritel Stetus 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yas, Give Yaar or Detes: 1 Nevar Married 2 Married Specify: White Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other treumatic event, me Item Elementery/Secondery (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ances 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mol spouse IIMONIUM 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other 0 20c. Location - City or Town, Stete 1 X Burlel 2 Cramation 3 Ramoval from State Department o Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Mom Gans 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility vans Part 1. Enter tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert fellure. List only one ceuse on each line. Approximata Interval Between Onset and Deeth Physician CHRONIC OBSTRUCTIVE LUNG DISEASE Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to for as a consequence of: Box 68760. Physician/Medical the Due to (or es e consequence of) for use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 15 Yes 2 No 3 Probably 4 Unknown HYDERTENSION Division of Vital Records. þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? paga 2 should Medical Certification: To Be Completed certificate has 1 ☐ Yes 2 1 No 1 Yes 2 No or Attending Physician: tha funeral director, 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Deeth 28d. Describe how injury occurred After 28c. Injury at Work? t (PNatural 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29e. Certifier 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 00 completed gause of deeth (Item 23a) (Type, Print) 30. Name and address of person who 7401 31. Date filed (Month, Dex.) 1°1'9 State Registrar

ORIGINAL

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sister Mary Josephita Larrea, OSP 2000 01 9:45a.m /Medical 4a. Fecllity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Oblate Sisters of Providence (HCU) Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Hours 1□M 288 F 98 Yrs. **Director** 214-56-0705 03-29-01 Cuba Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show notified at 1 ☐ Yes 2 TRNo Directo Baltimore Baltimore (Catonsville) the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 238 21227-3899 701 Gun Road USA Funeral Кеттв 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: Never Married 2 ☐ Married 'natural', or Specify: by 3 Widowed 4 Divorced Cuban Hispanic the Medical Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 end 2 should be filed within Health and Mentel Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Teacher School Ph.D. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clotilde Melgares Juan Domingo Larrea 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar Important: If item 27 is any injury or other traughts. 21227-3899 Sister M. Alexis Fisher, OSP 701 Gun Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date Peges 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 1-20-2000 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility March Funeral Home I and 3 ano 4300 Wabash Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) acute myocudial maret. /Medical Examiner Examiner physician end the buriel-trensit Syear Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last 99-00 Box 68760. y lan Physician/Medical Due to (or as e consequence of). 1999-00 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 0 RECENT PREUMONIA with Sa Jevenia -1 Yes 2 No 3 Probably 4 Unknown Completed by Records, specteuin, arteriorclautic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 22 No 1 Tyes 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 24 hours efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of certifier 100009293

State Registrar

DHMH 16 Rev 6/95

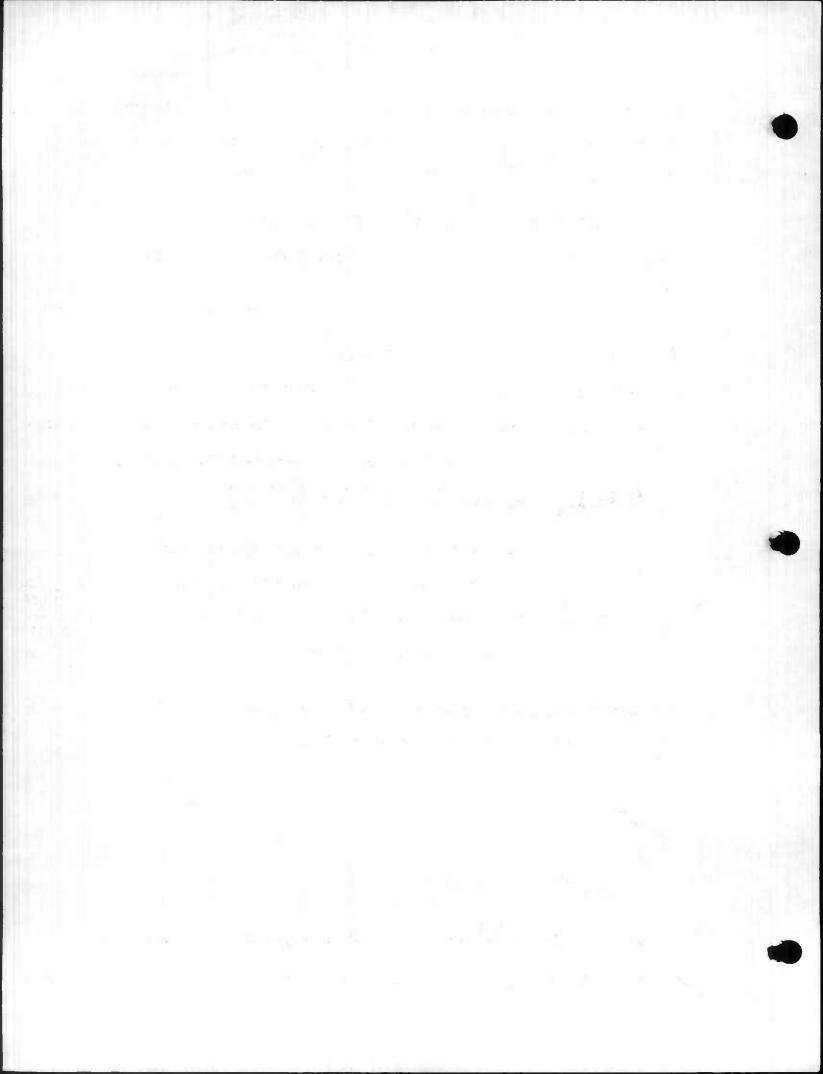
31. Date filed (Month, Day, Year) JAN 1 9 2000

RAFAEL. H.

32. Registrar's Signature

and address of person who completed cause of deathy(Item 23e) (Type, Print)

345 WILKENS AVE, BACTO MD21229



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #23a PER MD G779 1/19/2000 AH Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** MARTHA LEVIN 8145 PM SANUARY 08 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funera! Days Hours 1 M 2 XE Yrs Director 216-16-2756 JUL. 26, 1922 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inalde City Limits Itam 27 is marked other than "naturel", or items 23s or 25s-f show other traumetic event, the Missical Examiner must be notified at 28a-f ahow 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code #1 21218 21 E. 22ND STREET U.S.A. Funeral death permit. Peges 1 and 2 should be filed within 72 hours after dea. Cepartment of Health and Mentel Hygiene. Important: if item 27 is marked other than "net all injury or other traumatic. 12. Was Decedant Evar in U,S. Armad Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 🖾 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) LEVIN LAHAN **ABRAHAM** FANNIE 10 21218 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LOUIS BLOOM / SON 3001 N. CALVERT ST., BASEMENT REAR - BALTIMORE, MD 20b. Place of Disposition (Neme of cametery, crametory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ADATH YESHURUN SODOVA 1/10/2000 BALTIMORE, MD 21. Signature of Funeral Servica Licenses 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final TAULINE COR PULMINATE (PULMINARY TO A THE PERTENSION) disaese or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner physician and the buriel-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760, certificate be Physiclan/Medical Due to (or as a consequence of): 88 USB 0 Parl II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by (1 Yss 2 No 3 Probably 4 Unknown PULMCNAMY ALPENTENSION Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu hes page 2 2 3 No 1 ☐ Yes 2 No certificate funeral director. 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 1 Yes 2 No 3□ DOA 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Attending 1 Natural 5 Pending 2 No death. 1 Yes investigetion 2 ☐ Accident or Attend efter death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 D Homicide Hospital 24 hours 8 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) To the I 29b. Signature and Hittly of centile 29c. License number 29d. Dete signed (Month, Day, Year) MO. JANUAY 08, ATZ438946 30. Nama and address of person y no completed cause of death (Item 23a) (Type, Print)

State Registrar JOHN HUANG

31. Date filed (Month, Dey, Year)

206

JAN 1 9 2000

UNIVERSAY

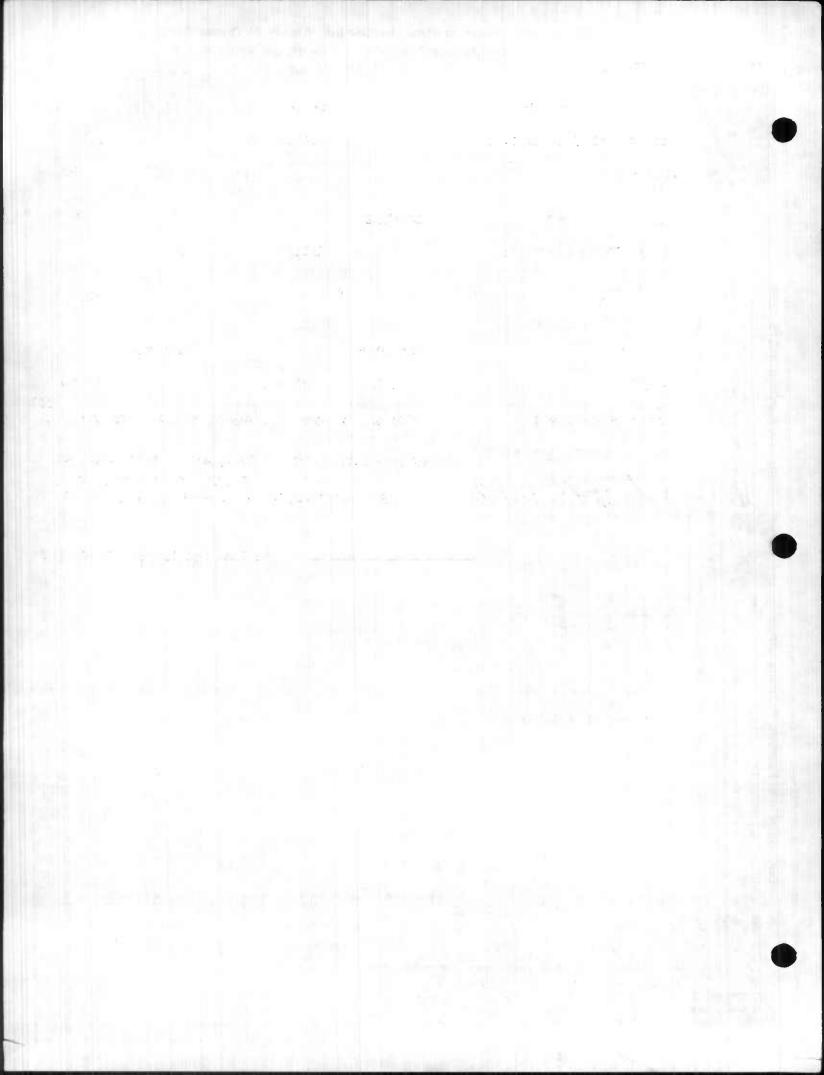
2. Registrar's Signature

INKY

BACTIMENE

MO

21218



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 3:55 p.m. January 14, 2000 Doris May Lloyd 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Towson If Under 24 Hrs. Stella Maris Baltimore 8. Dete of Birth (Month, Day, Year) April 20, 1922 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1□M 20X F Months Days Hours Min Delaware Yrs. 222-09-1676 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21224 812 S. East Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Midowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Assembly Line Appliance yrs. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Edna Cook Davis Oscar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Jarrettsville, MD 21084 3517 Glen Oak Drive Mr. Warren Lloyd 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Bunal 2 □ Cremetion 3 □ Removal from Stete 1/17/2000 Baltimore, MD Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hartsock, Jr 22. Name and Address of Facility Leonard J. Ruck, e of Funeral Service Licensee Paul L. Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 MOURIN 23a. Pent 1. Enter the disease, or complications that shock, or heart failure. List only one ceut of the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, Approximete Intervel Between Onset and Death Colon Immediate Cause (Final disease or condition resulting in death) Cancer Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Bother (Specify) Hospice 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

as the bunal-transit The law requires that the death certificate be axecuted been signed by the attending physician and should be detached for use as the bunal-trar 68760 Box (P.0. certificate has

Physician/Medical Examin py Completed Be To Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death N Department of Heelth and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Nama 234 any Injury or other traumatic event, the Medical Examiner must enge.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0020

なっついる

the Maryland

Records, Division of Vital To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

State Registrar

Medical

29b. Signature and triber certifier

29c. License number

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) end menner steted. 29d. Date signed (Month, Dey, Year)

D4372(

1117/00

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

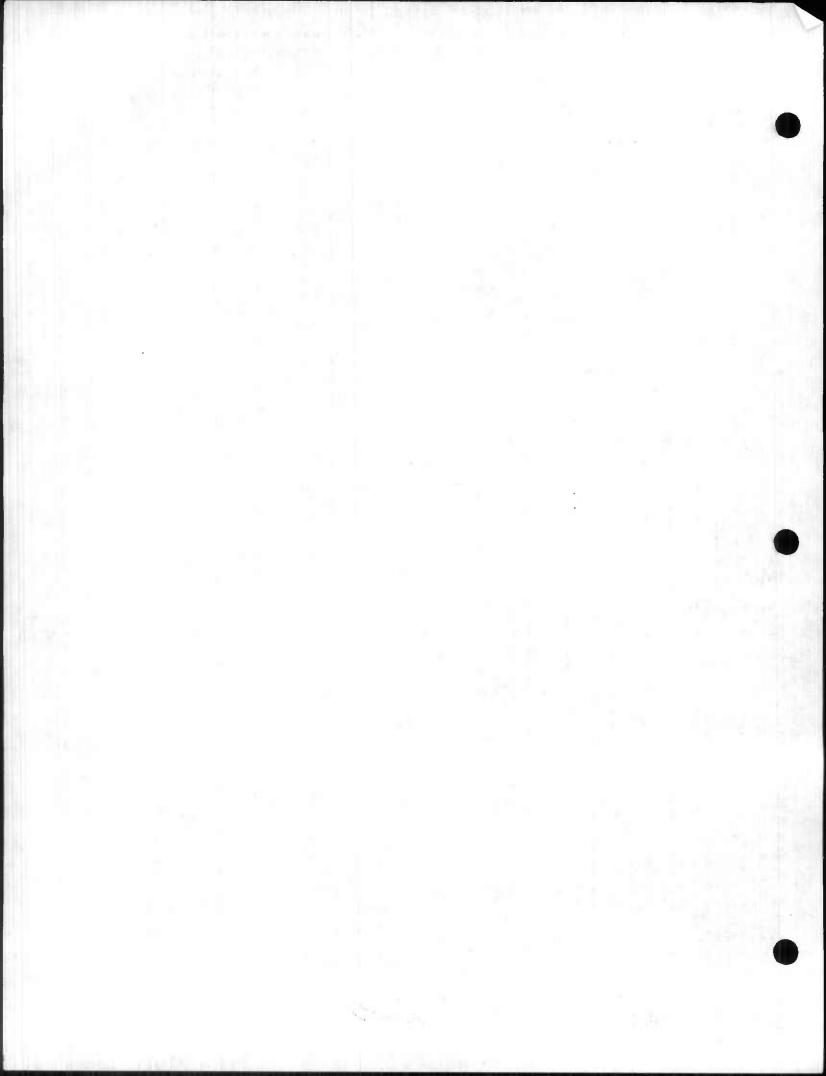
201-109 Back River Netk Road Baltimore MD 2/22/ TARIQ MAHMUOD

31. Date filed (Month, Day, Year) JAN 19 2000

4 Homicide

29a. Certifier (Check only one)

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month SALVATORE LIBERATORE 20000 SANUARY 15 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BACTIMORE (1+) INE Johns Hopkins Hospi+AL 5. Social Security Number 6. Sex 7. Age (In yrs. last bit N/A If Under 1 Ye 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Months 10XM 20 F Yrs. 218-28-6470 68 Jan. Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 IXI Yas 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6603 Fair Oaks Avenue United States 21214 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black White etc. 1 Never Married 2 Merried 1 X Yes 2 No If Yes, Give Year or Dates: Korea 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tailor / Distribution Foreman Clothing Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dominic Liberatore Ida Mulinari 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Thomas Liberatore / Son 1404 Cox Landing Court Baltimore, MD 21226 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Dother (Specify) Entonoment Most Holy Redeemer Cemetery 1/19/00 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Neme and Address of Facility Leonard J. Ruck, Inc. Funeral Home 23a. Pert1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tell into List only one cause on each line. Baltimore. MD 21214 Approximete Intervel Between Onset and Death Immediate Cause (Finel YOCARDIAI NFARCTION Hours disease or condition resulting in death) Due to (or as a consequence of) YEARS RONARY HRTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 000 2 No RIPHERAL 4PERTENSION IS EASS 24b. Were autopsy lindings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 0 No 1 Yes 2 No 26. Place of Deeth (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work?

Examiner I or Attending Physician: The law requires that the death certificate be associted after death.

Director: After this certificate has been signed by the attending physician and in by the funestidirector, page 2 should be detected for use as the burish-transit Box 68760. Physician/Medical PO signed by t d be detact Division of Vitai Records,

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

23a or 28a-f

Herman,

ò

Hygiene.

int of Health and Mental H till Nem 27 is marked off y or other traumatic even

Department of important: If any Injury or

Physician /Medical

Examiner

hours after

Pages 1 and 2 should be flied within 72

21215-0020

Maryland

altimore,

þ Completed 8 25. Was case referred to medical axaminer? 1 Yes 2016 Certification: To 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 Homicide edical Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and who of certif 29c. License number 29d. Dete signed (Month, Day, Year)

RES-000

2000

,15,

January

To the Hospital or within 24 hours aft To the Funeral Di completaly littled in

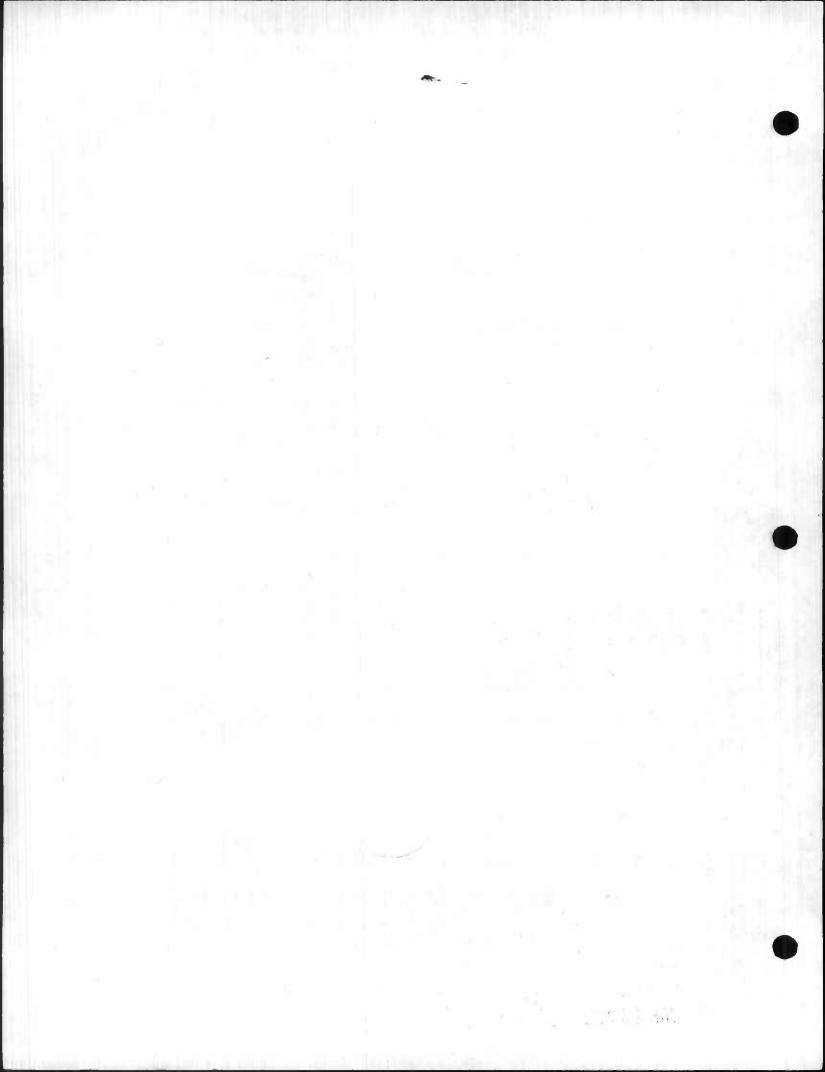
State Registrar

Stephen D. WIVIOTT 31. Date filed (Morith, Day, Year) JAN 19 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

JOHNS HOPKING HOSPITOL 1600 NOVY WOLFE STEET, BRITINGE MARYLAND 21287 32. Registrar's Signature couls



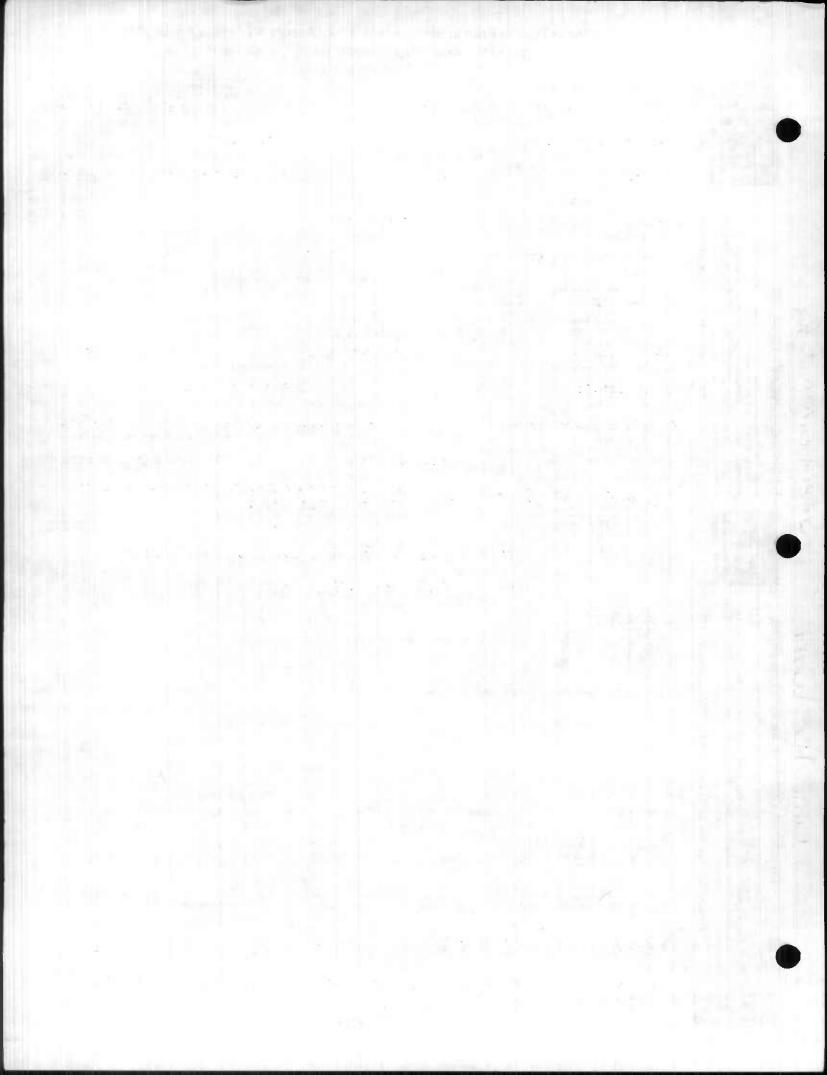
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 30 **Physician** illie MAR LPAZEr An 5 (1) /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number, 4c. County of Death Examiner BALTIMORE CITY N/A 2912 KEYWORTH AVENUE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociei Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months Deys 1 M 2KDE Yrs. SEPT 23 1942 SOUTH CAROLINA **Director** 57 220-36-5934 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits of 2 should be filed within 72 hours after death with the Marylan th and Mental hygiene.
7 Is marked other than "natural", or liems 23a or 28a-f show traumatic event, the Medical Easth or count or count. tXX es 2 □ No Directo BALTIMORE CITY MARYLAND N/A 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 2912 KEYWORTH AVENUE Funeral 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes ZXNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: BLACK by 3 ☐ Widowed 4 🖾 Xivorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 10th grade BINDERY WORKER ADVERTISEMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) WILLIE ALSTON ANNETTA KENNEDY permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4521 Finney Avenue, Baltimore, Maryland 21215 Tina C. Leazer/Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriai 20 Cremation 3 ☐ Removel from State METRO CREMATORY 1-21-00 BALTIMORE, MARYLAND 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervei Between Onset and Death **Physician** Quemous Cell Carona /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Concer Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es a consequence of): and physician a s the burial-Physician/Medical Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 2 signed by t 1 Yee 2 No 3 Probably 4 Munknown ģ 24b. Were autopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? 1 Yes 20No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yea 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Yea 2 No 2 Accident after death Director: 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours a Funeral C Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) To the P 29c. License number 29d. Date aigned (Month, Day, Year) 29b. Signeture end title of certifiers DO017386 cause of deeth (item 23e) (Type, Print) Bultmore, MD 21221 Standi Ford TOA /32. Registrer's Signeture State

Registrar

(5, 2000

MANUARCH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFHG781 3/2/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MCDOWELL JESSIE . LE 2.00 AM JANUARY 16 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deet! Examiner CENTER BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7228 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months NOM 20 F Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rail, or items 23s or 28s-f show 1 Yes 2 No Director and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? apt do Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Bleck, White, etc. should be filed within 72 hours after ond Mental Hygiene.
marked other than "netural", or item 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ITO, HOUSING permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any Injury or other traumatic avant, apple. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 19a. Informant's Neme/Reletionship (Type, Print) (Wite 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ne 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete, 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 DRemovel from State 2000 4 Donation 5 Other (Specify) 11995 21. Signature of Funerel Service Doenses 22. Name end Address of Fecility Funeral Balto Joseph W. North Ave 23a. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feit/re. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel RIGHT CEREBRO VAS CULAR ACCEDENT . MASSIVE disease or condition resulting in death) Examine Due to (or es a consequence of) Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): physician at the burial Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yas 2 No ARTERY CORONARY DISEASE Records, P The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? CARCINOMA OF PROSTRATE Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affer 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) illed in by 4 Homicide • Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier completely within 2 ş otto 29b. Signature and title of contil 29c. License number 29d. Date signed (Month, Day, Year) P12090 M-D JANUARY 16 2000

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

SUMABALA

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

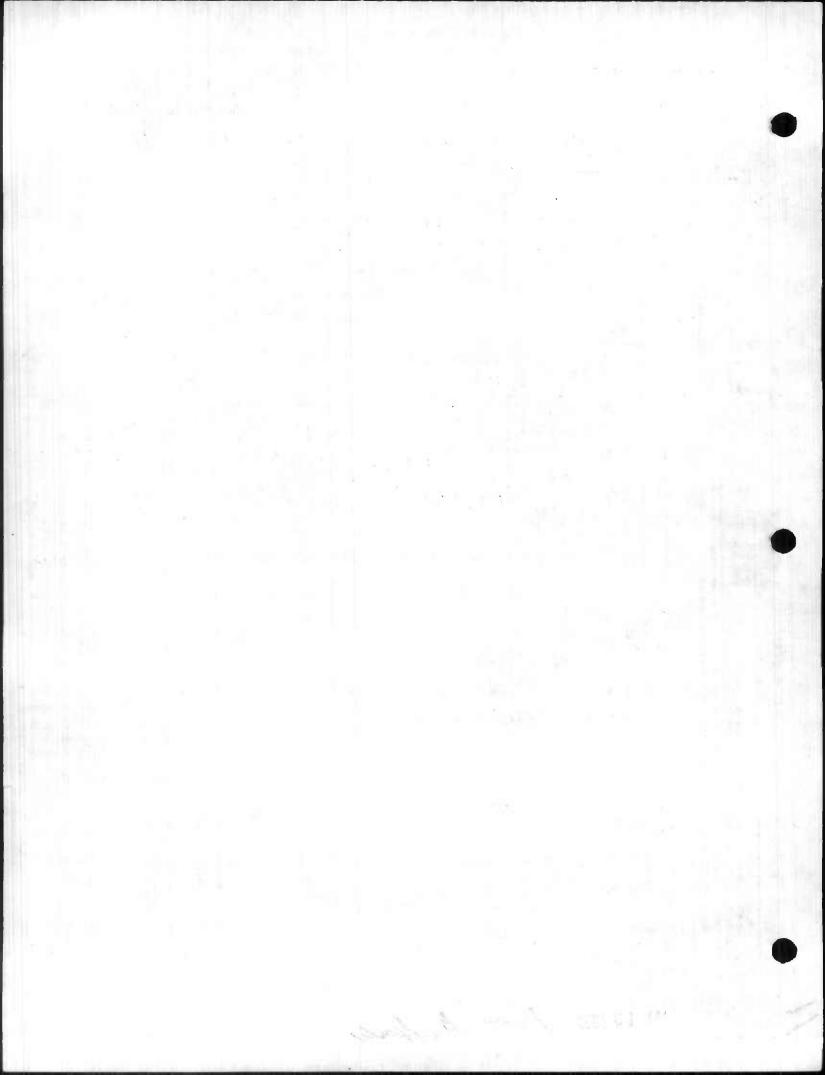
KASTBHOTLA

32. Registrer's Signeture Spark

ORIGINAL

3001. S. HANDYER ST

BALTIMORE MD 21225

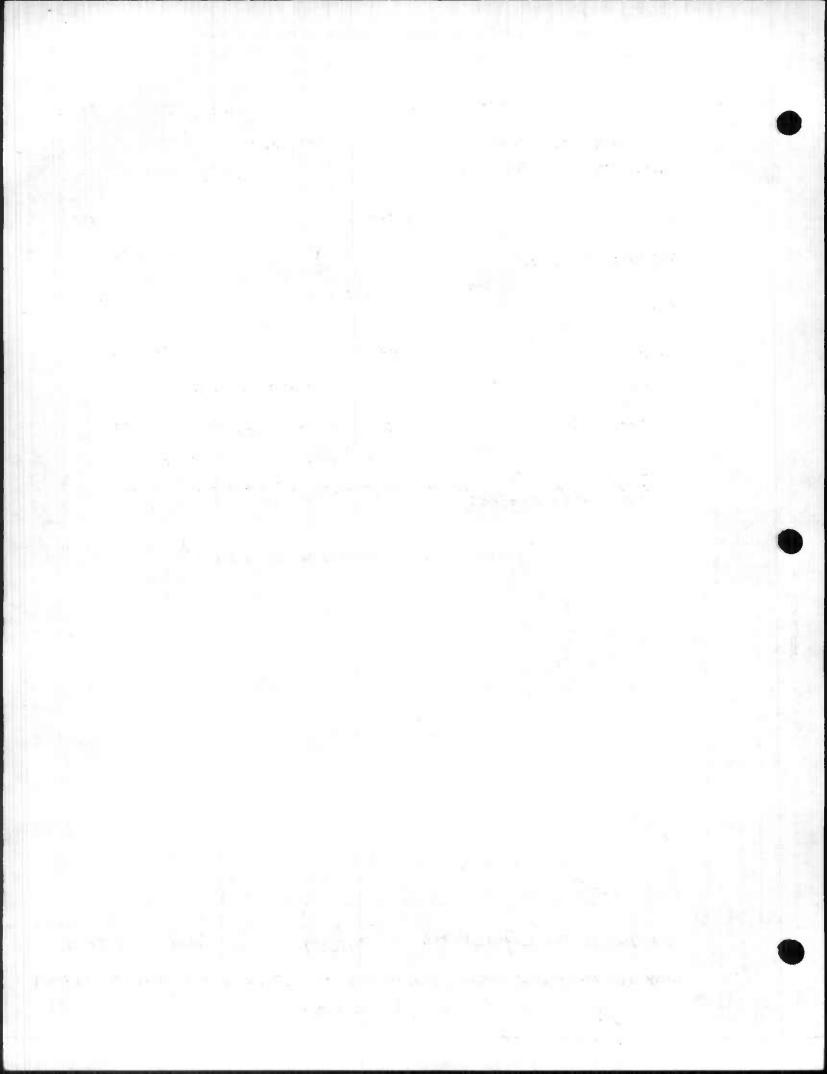


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** Eva M. Marvel Jan 16, 2000 9:00pm /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Nursing Home Baltimore If Under 1 Year | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2/2/XFX 186-14-5365 97 Yrs Director July 11, 1902 Reading, Pa Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits XIXXYes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 U.S.A. 700 West 40th Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxtcan, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, etc. 72 hours after 1 ☐ Yas 2XXXX If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tes 2/0/N/6 þ Specify: White ¾(X)√(idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Haelth and Mental Hygiene. Important: if item 27 is marked other than "n any lijury or other traumatic event, the Mad 900.8. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Unknown Own Home 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph 2 Magdalene Kleuh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Meadow Glen Wyomissing, Pa 19610

Of Disposition (Name of Date 20c. Location - City or Town, State Don Marvel (Son) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXX burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gethsemane Cemetery Laureldale, PA 21. Signaturmot Funeral Segrice Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician . Advanced Chronic Phatruckine lung disease /Medicai Immediate Causa (Final disease or condition resulting in death) 20 years Examiner Due to (or as a consequence of) Examiner attanding physician and for usa as the burial-transit certificata be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consaquence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? signed by ti 1 Nos 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to complation of causa of death? s cartificata has been si director, page 2 should 24a. Was an autopsy performed? Marvel this cartificata 1 ☐ Yes 2 ☐ No 1 Yas 2 No or Attending Physicien: 25. Was case referred to medical 28. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident To the Hospital or Attendithin 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Scartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler Medicai completaly (Check only 29b. Signature and titla of certifier

M Itabelle Mac 29c. License number 29d. Date signed (Month, Day, Yaar) D13657 Vahuary 18,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. BIBBLLE MACGREGOR, KESWICK MULTI-CARE CENTER, 700 W. 404 ST. BALTIMORE, DD 21211 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 19 JAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cei	tificate	e of	Death			Reg. No.			
Physic /Medi			me (First, Middle, La OUIJE	MAKT	10/						2. Dete of De Month	Dey /5	Year - 2000	3. Tima of Death	
Exami		4a Facility Name	(If not institution, giv	e street and number)				T	4b. City, Tow	vn, or Lo	cation of Deeth	4c. C	ounty of Deeth	10100	
		BonSe	ecour Ho	spital					Balt:	imo	re		NA		
Funeral Director		5. Social Security 214-26		7. Ag	e (In yrs. I 78	ast birthday) Yrs.	If Under		If Under 2 Hours	24 Hrs. Min.	8. Dete of Birt (Month, Da)		9. Birth	plece (Stete or Foreign ntry) NC	
2 .		Usual Residence	1										Т		
death with the Maryland ms 23e or 28e-f show creat be notified at	otor	10a. State MD	10b. County NA		y.Town or Location								10d. Inside City Limits Yes 2 No		
80 B	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Co									n of Whet Cou	ntry?			
W S S S S S S S S S S S S S S S S S S S	777	1304	oor	or 21217					USA						
3 22	by Funeral								t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)				14. Reca - American Indien, Bleck, White, etc. Specify: Black		
21215-0020 d within 72 hours at pens			15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usuel Occupation (Give kind of work done during most of work			of work					
2 2 2	Completed	Elementary/Sec		College (1-4or 5	i+)	life. DO NOT use retired)			ist of working						
CA DOF		12th Grade NA				Housekeeping						n & out of home			
D STEE	Be	17. Father's Name	e (First, Middle, Last)						18. Mother	's Neme	e (First, Middle,	Maiden Su	ımeme)		
/la	10	Walte	er	J	Eula			a	Mayes						
Maryland d 2 should be lie in and Mental Hy I is marked other traumatic event		19a. Informant's		19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stat						own, State, Zi	Code) 21217				
CSNL		Eula	Marti	n		1304	Har	len	n Aver	nue	Balti	more	, Mary	yland	
altimore, mit. Pages 1 a partment of Has portant: If Ilam y Injury or othe		20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, cremetory or other place) Baltimore Nat'l Cem. 01-20-2000 Baltimore, M.													
Balt permit. Depart Importu		21. Signanyo da 1	Duff	t du	2						ltimor			nd 21202 enue	
Physician		23m Part1. Enter shock, or he	the disease, or consent feilure. List only	one caused one cause on each lin	i the death ne.									Approximate Interval Between Onset and Deeth	
/Medical Examiner		Immediate Cause disease or condit resulting in death	ion	a. Aus	9Ki	2 5	uce	pe	halo	P	ally			2 des	
2 =	reul			, Car	L CV 2	res a conseq	mence on	12	_						
ocatificate be executed ding physician and set the burlel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury					or as a consequence of): Which here has a consequence of): The sa consequence of):						1		
Box 68	clan/Med			d									1		

by Physician/Medical Exa Completed Be Medical Certification: To

or Attending Physician: The law requires that the death certificate be exec

After this

within 24 hours efter deeth. To the Funeral Director: A

filled in by

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

27. Manner of Death
12 Natural
2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier

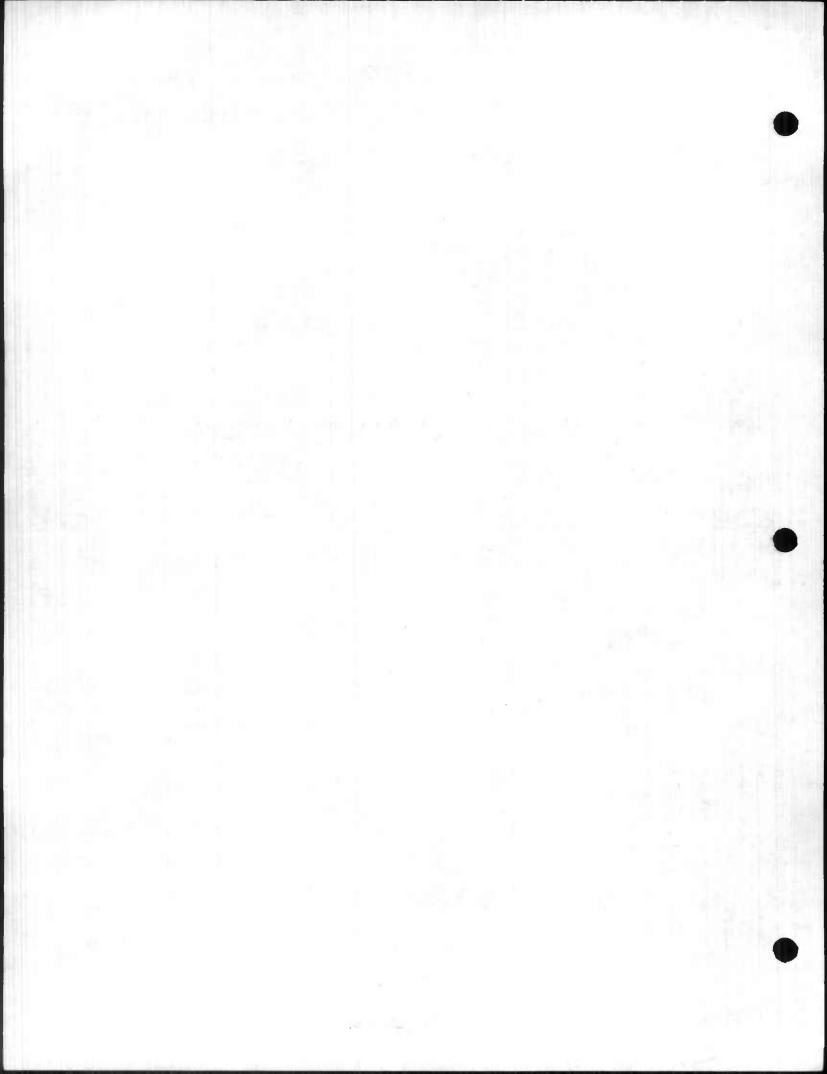
26256

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print), BCUTD WG, MD 700 W

31. Date filed (Month, Day, Year)

State Registrar

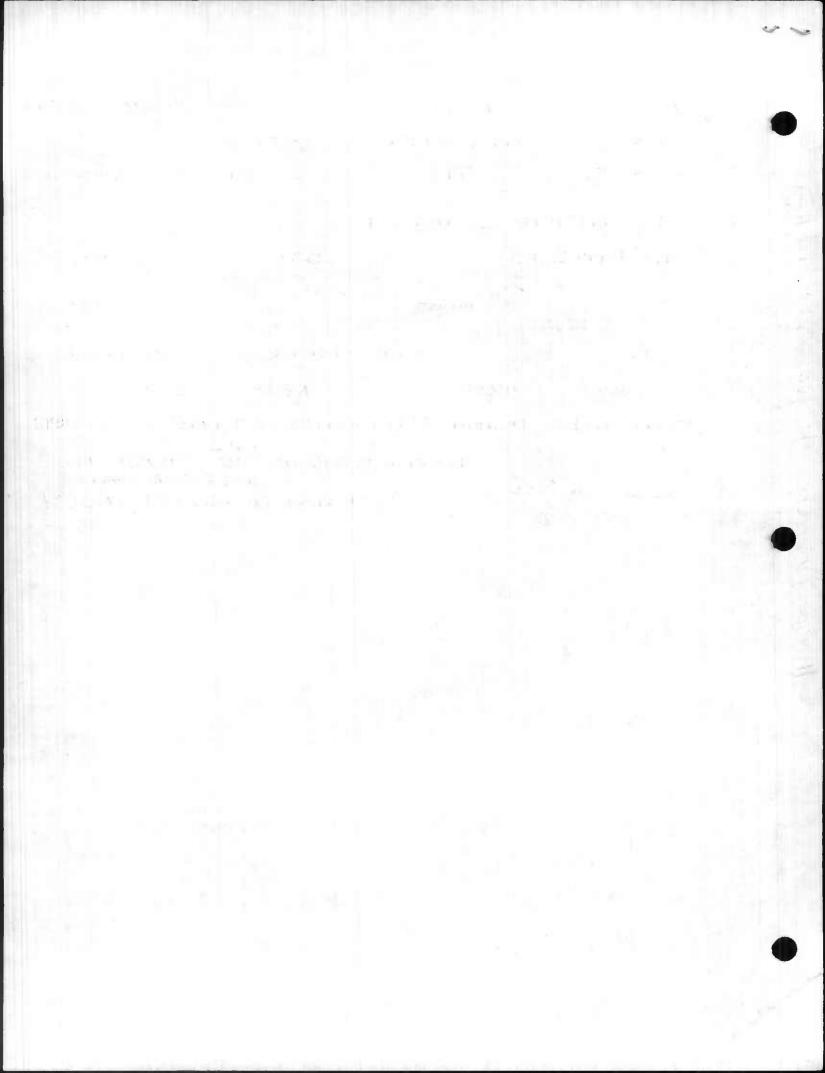
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2000 7:45 AM D. JAN MOORE NORMAN /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE
If Under 24 Hrs. 8 Date GILCHEIST CENTER G.B.M.C. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 12M 20 F 233-34-7951 Usual Residence of Decedent Director W. VIRGHNIA 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD. BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ FORREST 21234 U.S.A 7433 AVE Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: 21215-0020 by p 3 ☑ Widowed 4 ☐ Divorced Year or Detes: MARINES WHITE I Hygiena. Other than "naturn rent, the Medical i 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CUAIMS MANAGER 12 INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental STIFF SIDNEY NEWA MODER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Important: If Item 27 any injury or other to SONDEA GREENE, DAUGHTER 2517 FLAGG-MEADOW CT. FINKSBURGT, MD. 21048 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State JAN 21 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State Department 4 ☐ Donation 5 ☐ Other (Specify) DVLANES VALLEY MPM. GONS 2000 TIMONIUM, MD. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL terson 8800 HARFORD ED. PARKVILLE, MD. 21234 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer tailure. List only doe cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine) cancer 18 months diseese or condition resulting in death) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, PV 88 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Specify) Arypice Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Netural 5 Pending after death. Director: Af 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical pletely (Check only one) within 2 å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and Mile of confine 25205 17,2000 uns 30. Name and eddress of person who completed cluste of death (Ifem 23a) (Type, Print) N. Charles St. Balto, md GB MC 6701 0 31. Date filed (Month, Day, Year) 32. Registraf's Signature 21205 9 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Cation of Death 4c. County of Death FLORENCE METALLO 00 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Hopkins Hospita Baltimore The Johns If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1□ M 3□F Yrs. 215-30-7171 66 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Fort Howard 10e. Sfreet and Number 10g. Citizen of What Country? 10f. Zip Code 9124 Todd Avenue 21052 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Co. 12 Years Lab Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Kuhn Mary Platt 19a. Informant's Name/Reletionship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Metallo Asplen 8304 Berkwood Ct. Baltimore, MD 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) Hilltop Service Corp. 1/20/2000 Towson, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel Systemic Inflammatory RESPONSE Syndrome diseese or condition resulting in death) Interstitual Preumonitis Twelve Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BREAST CHNCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 18 Yes 2 □ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neture 5 Pending 1 Yes 2 No Investigation 2 Accident

be executed Box 68760. P.O. Records. Division of Vital

the 10 signed by t peed certificate this After or Attending death. To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A completely filled in by the fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

Rema 23a

natural, or

Hygiene.

and be fit.
T is mental He

permit. Pages 1 and 2 should I Department of Health and Man reportant: If Item 27 is market

Physician /Medical

Examiner

and

Physician/Medical

þ

Completed

Be

Certification: To

Medical

altimore. Maryland 21215-0020

Director

Funeral

à

Completed

Be

2

State Registrar

29b. Signature and title of certifier

3 Suicide

29e. Certifier

4 | Homicide

(Check only one)

ERIC JACOBSEN , M.D. 31. Date filed (Month, Day, Year)

JAN 19 2000

6 Could not be determined

MO

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 16 2000

21205

Location (Street and Number or Rural Route Number, City or Town, Stele)

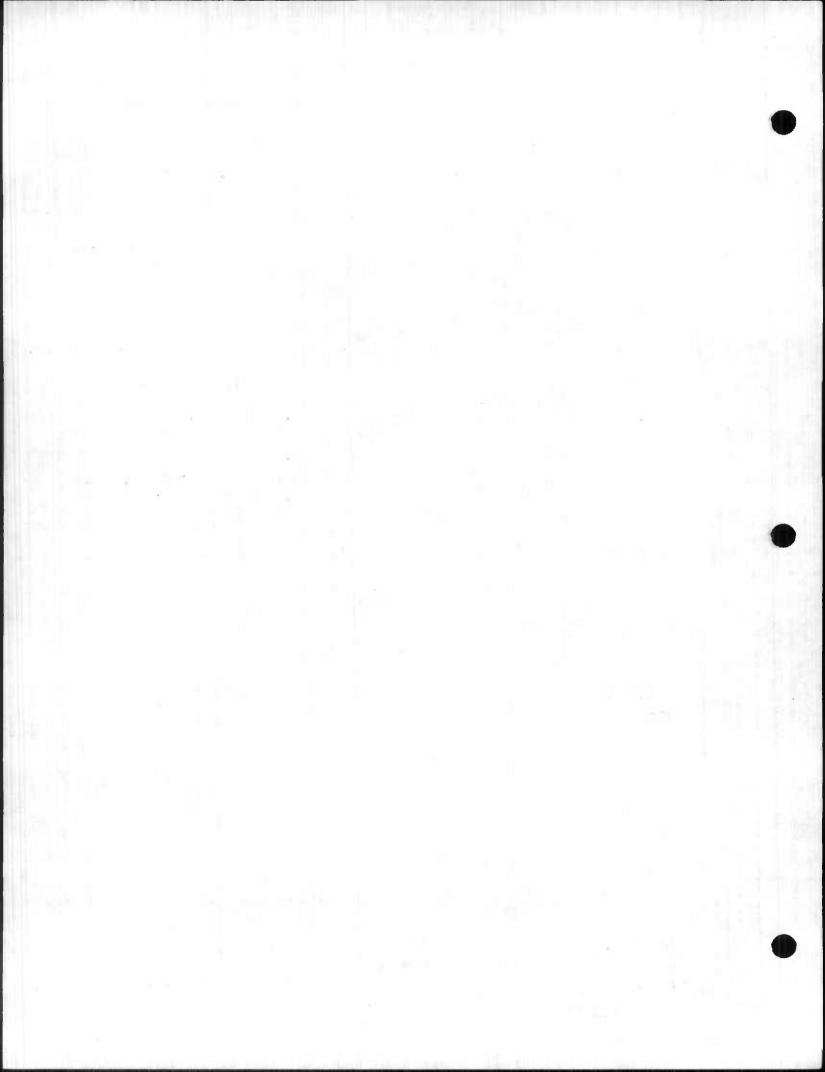
MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 NORTH WOLFE STREET

BALTIMORE

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Josephine Helen Miles 8:55 P.M. January 16 2000 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Ellicott City Howard St. Agnes Nursing & Rehabilitation If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Deys Hours 217 18 1468 87 April 17,1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WYes 2 No N/A Maryland Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21226 U.S. 1524 Plum Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S Armed Forces? 11. Marital Stetus 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Balto. City School 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Kolodziejski Frank Matecki 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Ellicott City, Maryland 21043 4642 Dower Drive Jean Smith Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 █ Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/20/00 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Gonce Funeral Home P.A. romunousky 4001 Ritchie Highway Baltimore, Md. 21225 cations that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, le cause on each line. 234. Pert1. Enter the disease shock, or heert failure. Onset and Death SEDSIS Immediate Cause (Final disease or condition resulting in death) 001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 DK 1 Yes 20 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be assecuted Box 68760, P.O. Division of Vital Records, or Attending Physician: s after death.

I Director: After this id in by the funeral di To the Hospital e within 24 hours a To the Funeral D

page 2 should be datached

3

this cartificata

Physician

/Medical

Examiner

Funeral

Director

, or items 23s or 28s-1 show

The Maryli

filed within 72 hours after

il Hygiene. other then

Mental

A mud A

of of Health :

Department of Important: If

Physician

/Medical

Examiner

Physician/Medical Examiner

þ

Be Completed

Medical Certification: To

29a, Certifier

(Check only one)

Pages 1 and 2 should be

Maryland 21215-0020

Baltimore,

the Medical Examiner must be notified at

Directo

Funeral

à

Completed

9 State Registrar

DHMH 16 Rev 6/95

completely filled in by

V 1 9 2000 31. Date filed (Month

29b. Signature and title of certifier

Meun

30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print) LAKHANI 7220 32. Registrar's Signature

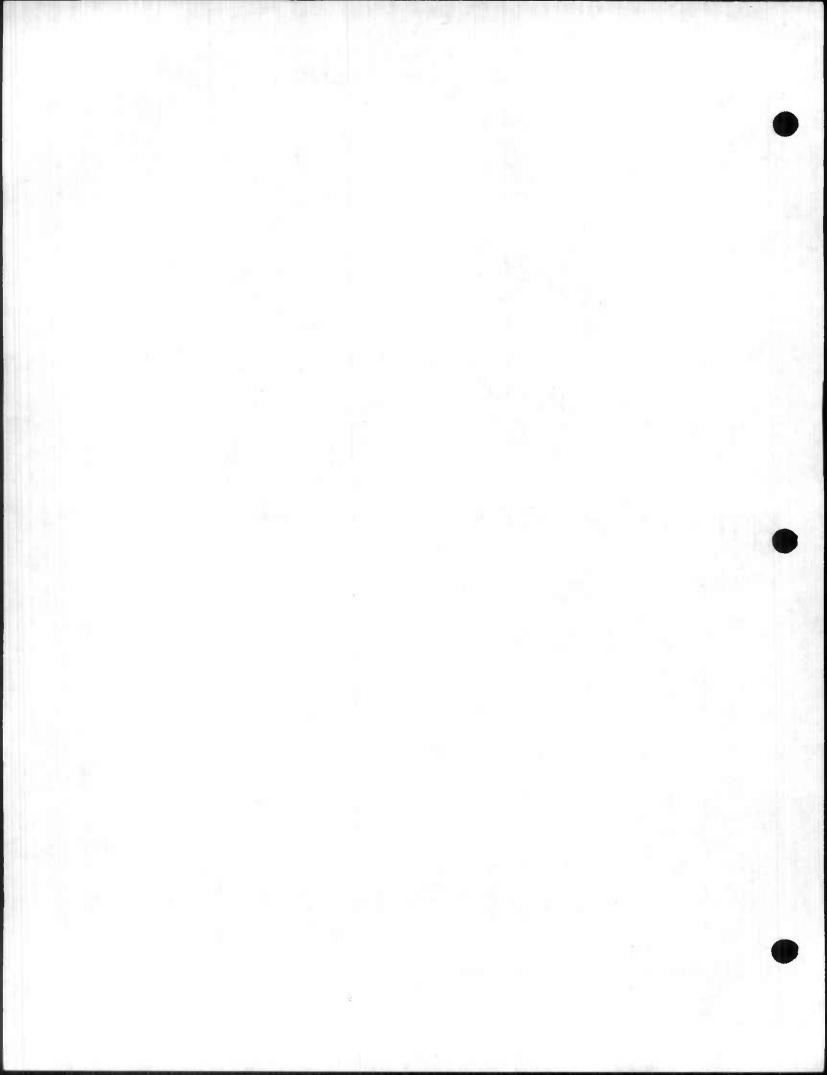
and manner steted.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)



00-0097-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm Unknown 00-007 State of Maryland / Department of Health and Mental Hygiene Christina Lynn Marden Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month **Physician** Christina Lynn Marden January 06, 2000 12:21 P.M /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 600 C Cherrycrest Road Baltimore N/A If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F Yrs. 456-61-4106 24 Director December 23,1975 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. Count or itsens 23s or 28s-f show 1 Yes 2 □ No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? the Medical Examiner must be 600 C Cherycrest Road 21225 United States Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Bled within 72 hours after 1 ☐ Yes 2 No If Yes, Giva Yaar or Datas: Never Married 2 Merried Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Bra. Elementary/Secondery (0-12) Cotlege (1-4or 5+) Homemaker Domestic 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Be 2 should be 1 and Mental 9 Ralph F. Marden Wanda S. Gray 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) . 1 and 2 Health Hern 27 Wanda S. Beane/ Mother 1627 Spruce Apt 2 Baltimore, MD 21226 Baltimore, 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, Stata Pages 1 1 ☐ Buriel 2 XCrametion 3 ☐ Ramoval from Steta Chesapeake Crematory Inc. 1/15/2000 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr. Baltimore, MD Laura Hardesty 21286 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequanca of) Examiner and Sequentially tist conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury Due to (or es e consequence of) The law requires that the death certificate be assect 68760 attending physician Physiclan/Medical that Initiated events resulting in death) Last Due to (or es e consequenca of) the Box P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? Probably 4 Unknown signed by 1 Yaa 2 No Completed by 24b. Wera autopsy findings eveilable prior to completion of causa of death? 24a. Was en autopsy performed? Yes 2 No 2 No this certificate I or Attending Physician: after death. Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Rasidence 6 Other (Specify) OL 1 XYas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Affer 5 Pending Investigation Injury 1 Neturat victing 1 Yes Longer 100 1206

Division of Vital Records. To the Hospital within 24 hours a To the Funeral Completely filled

Registrar DHMH 16 Ray 6/95

Director: A

filled in by

edicai

WW 31. Date filed (Month, Day, Year) State JAN 1 9 2000

29b. Signature and title of contifier

Accident 3 Suicide

4 | Homicida

29e. Certifier one)

6 Could not be datermined

606

w 32. Registrer's Signeture

30 Name and address of person who completed causa of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

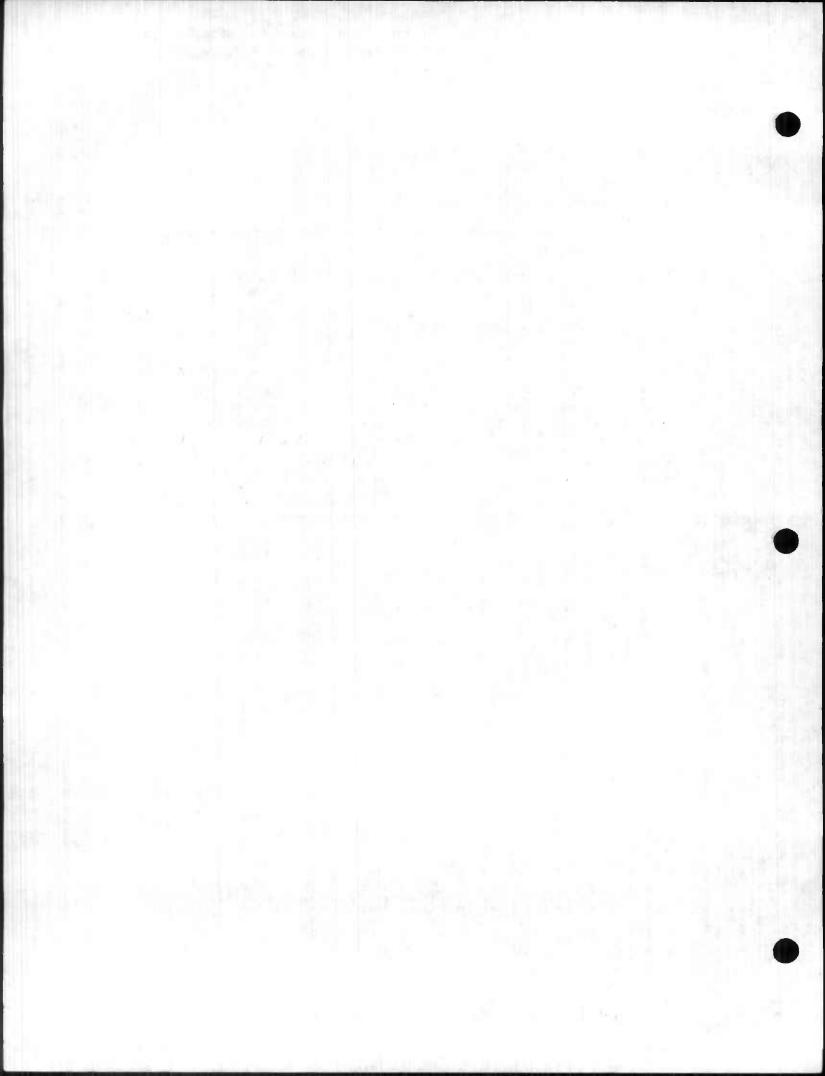
Purce of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Cortifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated. 212 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred at the time, dete and place, and due to the causa(s) and menner stated.

29c. Licanse number O.C.M.E. 28t. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

January 07, 2000



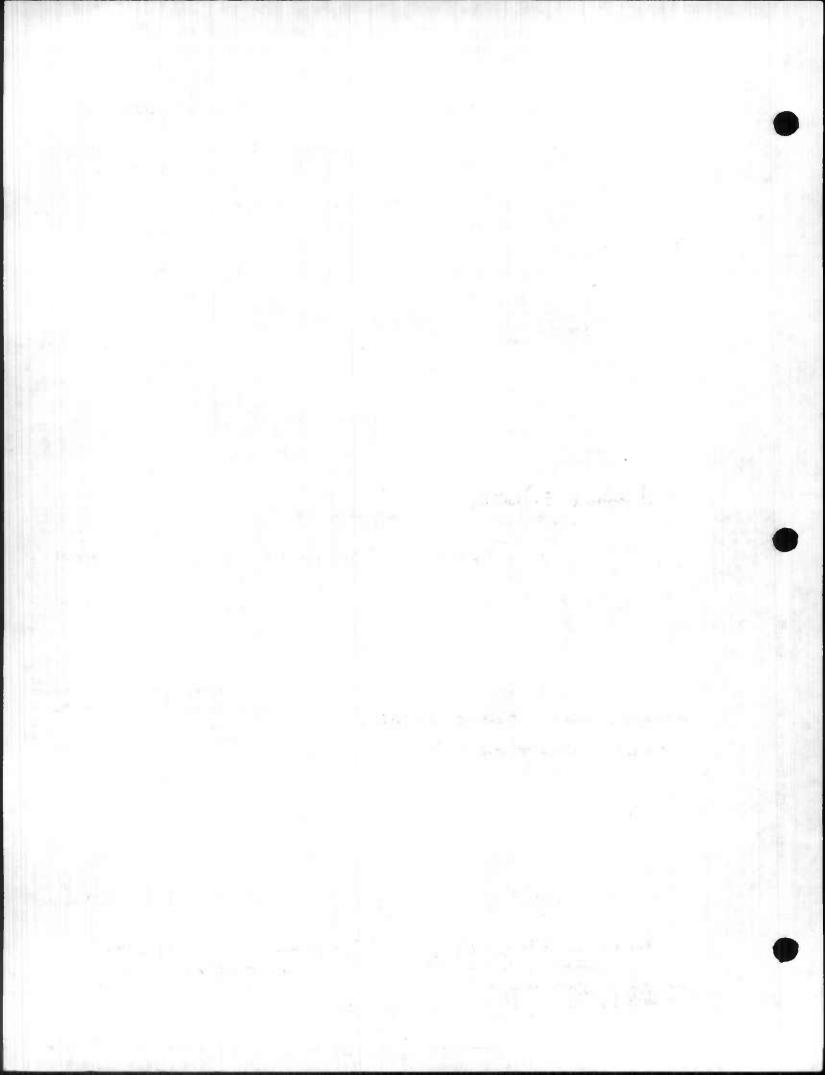
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** 8:30p.m Parlett January 8, 2000 cation of Death 4t. County of Death /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Examiner Health Mariner 9. Birthplaca (State or Foreign Country)
7, 1907 MG. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) **Funeral** Year) 92 219-36-9912A Months Days DOM 20 F Director Usual Residence of Decedent 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits Pikesville Baltimore Md. 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 7430 Ricksway Road Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ Mo If Yas, Giva Year or Dates: 1 ☐ Never Married 253Married **Black** 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Coppin State University Educator-President 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Noah Moore Maggie Thomas 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel C. Moore Sr. son 7430 Ricksway Road Baltimore, Md. 21208 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Slata 1 Deletial 2 Cremation 3 Removal from State Md. National Mem. Park Jan. 14 Laurel, Md. 4 Donation 5 Dother (Specify) 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses erbert 2501 Gwynns Falls PKWY Baltimore, Md. 21216 8 nutter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical DENENTIA YEARS ROGRESSIVE Examiner Dua to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burlai-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by the detach 1 Yes 2 No 3 Probably 4 Whknown HEART DISEASE Records, ģ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed (NANITIO SENILE this certificate has 1 ☐ Yes 2 No t ☐ Yes 2☐ No of Vital Attending Physician: 8 25. Was case refarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To vial or Atta.

ours elter death.

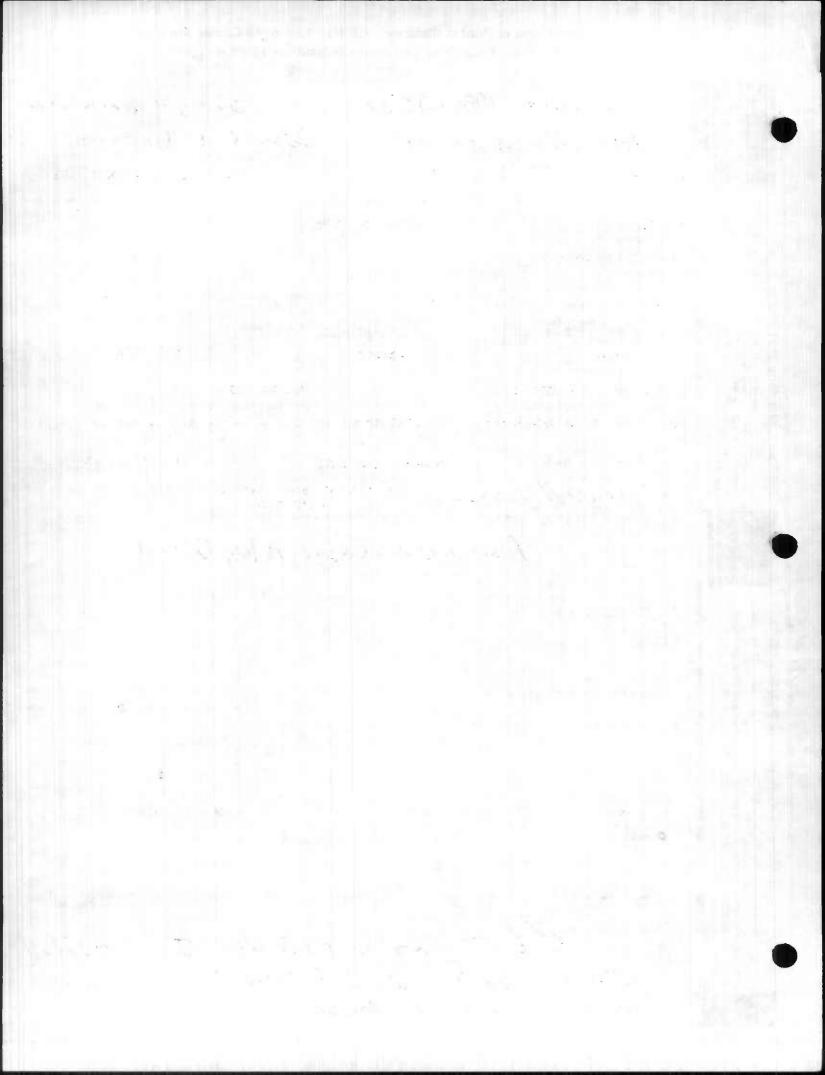
meral Director: After thir funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident Division 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the Hosp within 24 hor To the Fune completely ii (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 8 D08944 12/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT BUE. MALTIN C PHARGEG KENSINGTON MD-M.D 31. Data til Arthreti Day, Pelan Bagistraca Signature State outs Registrar

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2000 10:07 AM **Physician** ENOX DANVARY /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Baltimire City leterans Himore Haministration If Under 1 Year 6. Sex 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** Months Deys Min. PEXM 2 F 72 **Director** 204-18-3220 DEC 14 1927 PENNSYLVANIA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10e. Stete ir than "natural", or frams 23a or 28a-f show the Medical Examiner must be notified at 1XWas 2□ No Director MARYLAND BALTIMORE CITY N/A10g. Citizen of Whet Country? 10e. Street and Number 10f. Zlp Code 1607 N GAY STREET 21213 U.S.A. death Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Stetus Bleck, White, etc. o filed within 72 hours after if Hygiene. other than "nature!", or its ©XYes 2 ☐ No It Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 50/71 Specify: BLACK þ 3KWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MAINTENANCE 12th grade PORTER traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 12 should be fin h and Mental F ie marked out WILLIAM H MAULTSBY SR. JOANNA HAGAN 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 ie m any Injury or other traum page. Rev. Terry Forbes/Daughter 8313 Township Drive, Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steie 20e. Method of Disposition XXBuriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetiop 5 ☐ Other (Specify) 1-15-00 BALTIMORE, MARYLAND WOODLAWN CEMETERY 22. Name end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Atheroscleratic Coronary Artery Disense /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): physician Physician/Medical 94 that initieted events resulting in deeth) Lest Due to (or es e consequence of): 8 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records, 8 24e. Wes en eutopsy performed? 24b. Were eutopsy tindings evaileble prior to Completed completion of cause of death? Mas 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 928 certifica 25. Wes case referred to medical exeminer? Be 28. Piece ot Deeth (Check only one) Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 28e. Dete of Injury (Month, Dey Year) tion: 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Athar Attending 1 QNeturel 5 Pending 1 ☐ Yes 2 ☐ No I or Attend after deal! Director: 2 Accident Certificat 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title ot certitier 13416 Janvay MO 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 22 -HAIM 31. Dete tiled (Month, Dey, Year) 32 Registrer's Signeture JAN 1 9 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 4:01pm ROBERT JAMES MAITH SR. Lanuary 14 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Haspital Center 5. Social Security Number 1 6. Sex 7. Age (In yrs. lest birthd Baltimore 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) MD . Days 1₽M 2□F Months 213-14-5974 80 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 SERPENS CT. 21236 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ft Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. 14 Race - American Indian 11 Marital Status Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Merried Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -6--0-LABORER STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHN MAITH MALINDA LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY MAITH(WIFE) 7521 GUM SPRING RD. BALTIMORE, MARYLAND 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 1-22-2000 BALTIMORE, MARYLAND 22. Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses Than 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) · Acute Muccardial Infarction One hour Due-to (or as a consequence of): Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of ongestive Heart Due to (or as a consequence of) ardioxascular Disease tensivel Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Prostate Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation

Examiner Examiner that the death certificate be assecuted physician and the burial-transit Box 68760, Physician/Medical Division of Vital Records, P.O. þ The law requires Completed page 2 a or Attending Physicien: Be Certification: To 100 After efter death. 2 filled in

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f ahon

Director

Funeral

à

Completed

MD.

the Manyland

permit. Pages 1 and 2 should be filled within 72 hours effer death with t. Department of Heelth and Mental Hygiens. Important: if Item 27 is marked other than "natural", or Items 23s nr ? any injury or other traumatic avent, the important of thems 23s nr ? PAGE.

Hospital of 24 hours of Funeral D To the Hosp within 24 hos To the Fune completely fi 0

Registrar

Medical

31. Date filed (Month, Day, Year) 9

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

281. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

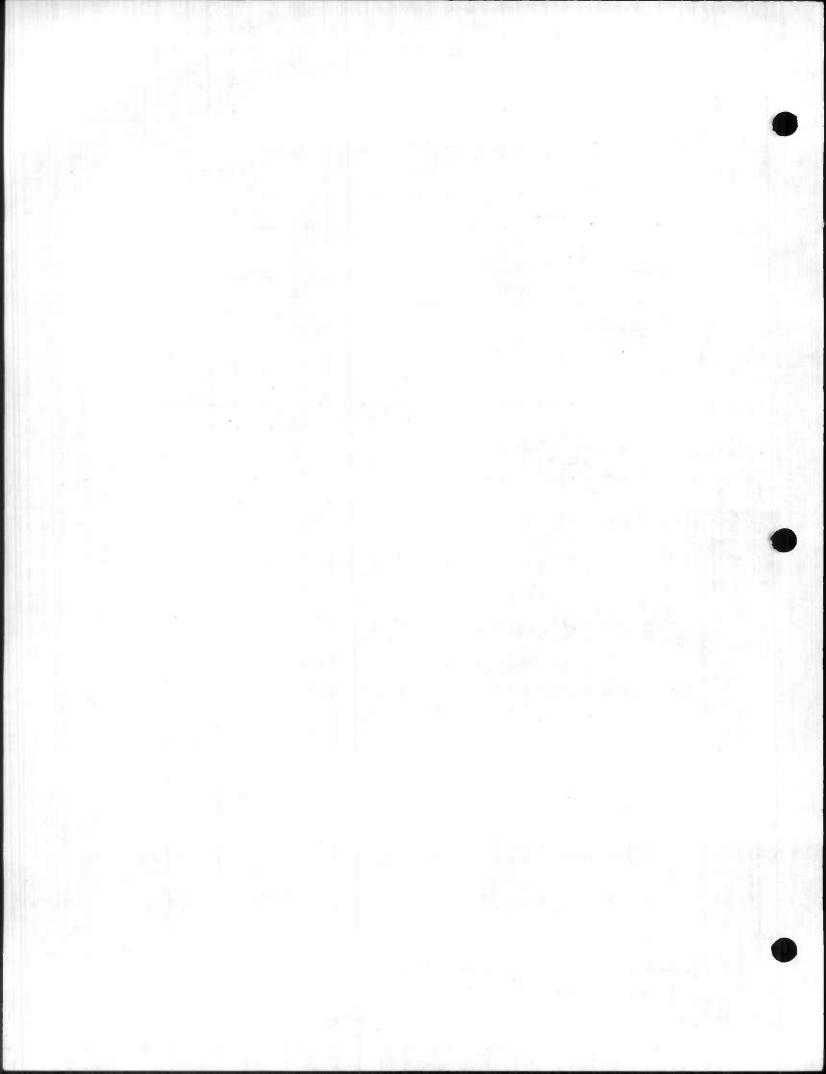
2000

6 Could not be

Dr Sunil Ahuia 9000 Franklin Square Drive Baltimore Maryland 21237

32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth Dey 7 H MILLER **Physician** 6:00 Am LEONORA TANVARY 2000 15 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) AUG. 31,1915 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 TF 84 MD Director 075-36-0357 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits BALTIMORE MD BALTIMORE 1 ☐ Yes 2 No No Director 28s-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 21208 U.S.A. #408 130 SLADE AVENUE 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 [XNo if Yes, Give Yeer or Dates: Hems Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be illed within 72 hours after nant of Health and Mental Hygiene. Int. If them 27 is marked other than "natural", or its any or other traumatic event, the Medical Examins. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yea 2 X No Specify: Specify: Àq 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be ROSEN SCHAPIRO FREDA DR. WILLIAM В 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 3218 HATTON ROAD - BALTIMORE, MD 21208 STANLEY SCHAPIRO / BROTHER 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State 1 \ Burial 2 Cremetion 3 Removal from State BALTIMORE HÉBREW CÉMETERY 1/17/00 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22 Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 occio 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) A CUTE TULMONARY EDEMA . Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or es a consequence of): P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) USe as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? MELLITUS. DIABSTES page 2 1 Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 npatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28s. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as stated. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number JAN 157 D 42723

DHMH 16 Rav 6/95

State

Registrar

oaks

HARISH

32. Registrer's Signeture

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

m

VYERAHALLI

19 2000

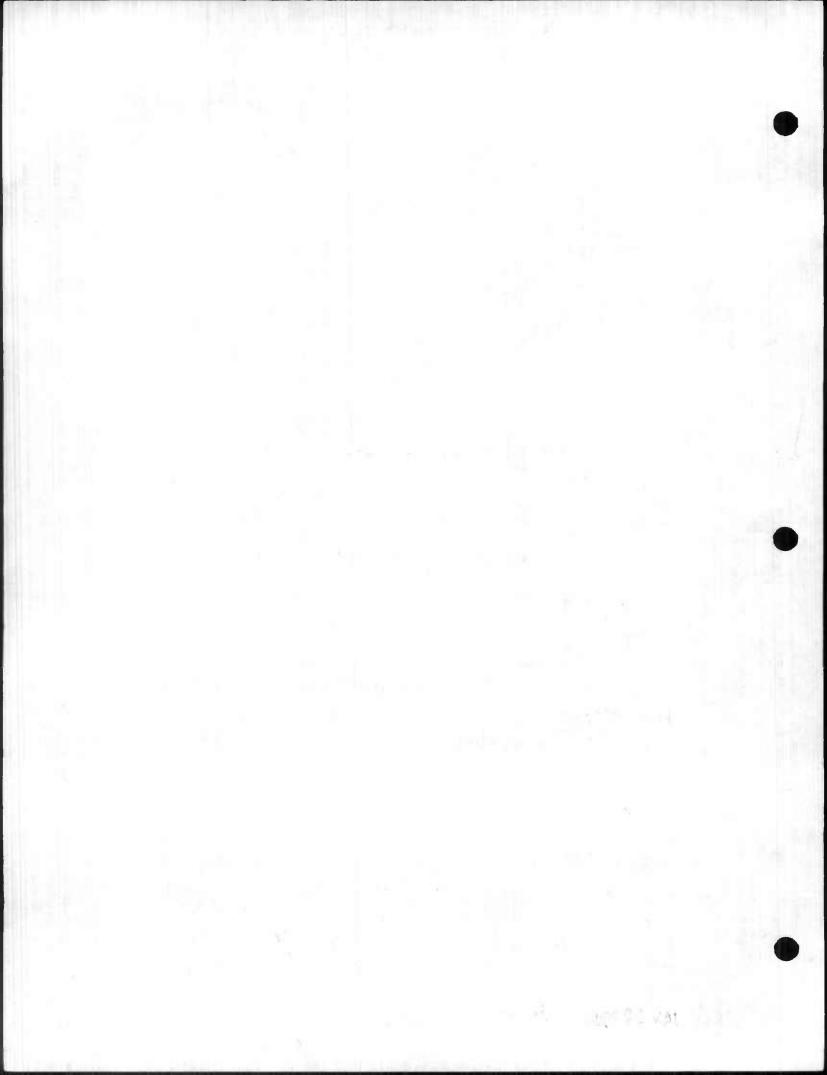
31. Date filed (Month, Dey, Year)

NORTHWEST HOSPITAL

RANDALLS TOWN

CENTER.

BARTIMORE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Evelyn Markel January 17,2000 7:30PM 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 15 Belinda Avenue Baltimore Baltimore If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 6/19/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1□M 2□F 79 217-03-4742 Yrs. Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 15 Belinda Avenue 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ÑNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 KNo Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Sales Lady Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma Jordan Harry Mumma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Markel 9522 Oakbranch Way Perry Hall, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Parkwood Cemetery 1/21/00 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Entire shock, or he Approximate Intervel Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes MINO 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Maturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. Records, P.O. Division of Vital

attending physician 88 signed by the a peed certificate after death.

Director: After this certifica 24 hours a Hospital within 2 **9**

Physician

/Medical

Examiner

Director

Funeral

py

Completed

Be

2

MD

Funeral

Director

r than "natural", or flame 23a or 28a-f ahow the Medical Exercitor must be notified at

the Manyland

death with

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 Is marked other that any injury or other traumatic event, the once.

Physician /Medical

Examiner

the burial-transit and

Physician/Medical

by

Completed

Be

Baltimore, Maryland 21215-0020

Medical Certification: To 29a, Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BALTO, MD

DRIVE

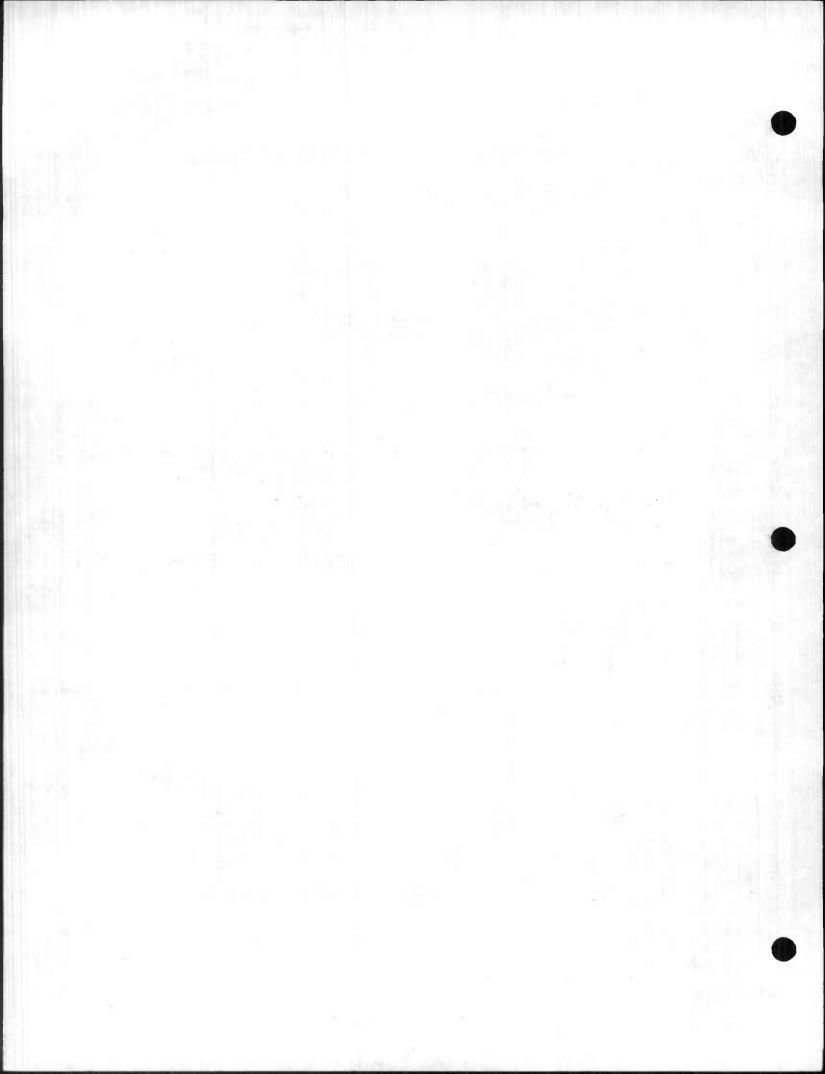
29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (item 23a) (Type, Print) 6830 HOSPITAL

MYO THANT 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** 2000 William Joseph Nemec Sr. 191 /Medical 4c. County of Deeth 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Mariner Health of Belair Belair Harford If Under 24 Hrs. If Under 1 Year 8. Dete of Birth Month, Day, Ye 6/29/1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Deys Hours 85 216-05-7952 Maryland Director Usual Residence of Deceden with the Meryland 10a. Stete 10c. City. Town or Location 10d. inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at MD N/A Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6018 Eurith 21206 U.S.A. death Funeral 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural", or ther any Injury or other treumatic event, the Medical Example. 1 Nes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 1 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education Elemantary/Secondery (0-12) College (1-4or 5+) Pipefitter B G&E 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Charles Nemec Rosalie Maravic 19a. informent's Neme/Raletlonship (Type, Print) 19b. Melling Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Nemec/Son 11 Mitchell Road Airville, PA. 17302 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 € Buriel 2 Cremetlon 3 Removel from Stete Garden of Faith Cemetery 1/18/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funanti Service License John C. MIller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Peri1. Enter the disease, or come ations that caused the deeth. Do not entar the moda of dying, such as cardiec or raspiretory errest, shock, or haart failura. List not one causa on aech line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Ceusa (Finel 6 months uncer disease or condition resulting in death) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceusa (Disaase or injury that initioted events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) USB 88 23b. Did tobacco use contributs to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. signed by t d be detect 1 Yss 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of daath? certificate has 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case rafarred to medical exeminer? 1 ☐ Yas 2 ♠ No 86 28. Piace of Death (Check only one) Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 1 Neturel 5 Pending death. 1 Yes investigation 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours a 1 Cartifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier January 16,2000 D34652 30. Neme and eddress of parson who complated causa of daeth (Itam 23e) (Type, Print) Mary Junes 2 North Avinus HASWILL 9

DHMH 16 Rev 6/95

State

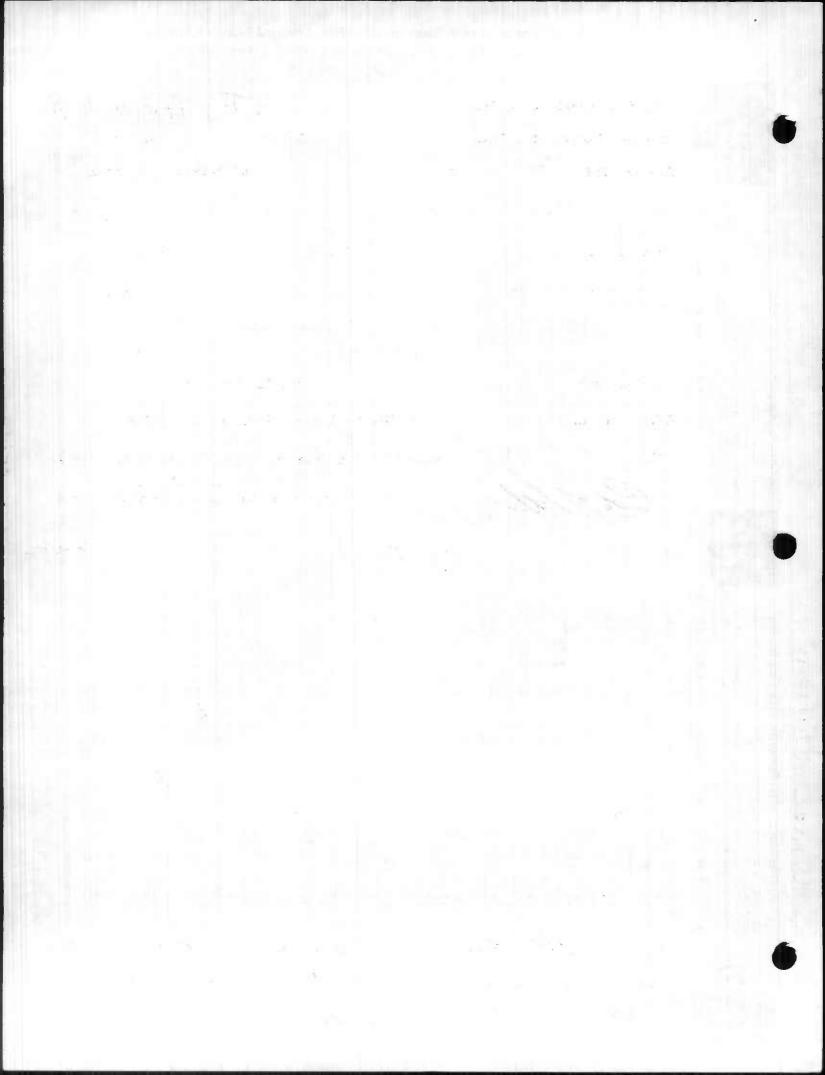
Registra

31. Dete filed (Month, Day, Year)

JAN 1 9 2000

32. Registrar's Signatura

Vernec, William



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 2:33p.m. 2000 Martha Cloud Ogilby 14, January 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Dey, Year) DEC 30, 19 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 6. Sex 1□ M 2ĂF Months Deys Hours Min. 82 Yrs. Texas 452-26-5955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yas 2 No Maryland Prince George's Beltsville 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11203 Cedar Lane 20705 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bieck, White, etc. 1 Never Married 2 Married 1□ Yes 2No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Emerson Cloud Ralph Anna Allan 19a. Informant's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6704 Flintrock Road, N. Little Rock, AR 72116 R. Scott Ogilby 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlet 2 Cremation 3 Removal from State Beltsville, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory INC 1/15/2000 Maryland 22. Name and Address of Fedility Rapp Funeral & Cremation Services, M00956 Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 20910 Shock, or heert feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequença of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yee 2 No 24b. Were autopsy findings aveilable prior to 24e. Was an autopsy completion of cause of death? 1 Yes 2 DNO 1 Yes 2 No 25. Was cese referred to medice examiner? 26. Plece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manufactured. 29e. Certifier (Check only

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

physician and the buriel-transit 50 980 0 the th signed by i peed has this certificate or Attending Physician: director, funeral After t in 24 hours atter the Funeral Director: Afternatately filled in by the funeral filled in by the completaly To the To the To the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

P

Completed

r than "natural", or items 23a or 28a-f ehor

permit. Pages 1 and 2 should be filed within 7; Department of Heelth end Mental Hygiens. Important: If them 27 is marked other than "na any injury or other traumatic event, the Meda-page.

Physician /Medical

Examiner

Examiner

Physician/Medical

à

Completed

Be

P

Certification:

edicai

with the Marylend

filed within 72 hours after death

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Dey, Year) JAN 1 9 ZUUU

29b. Signature and title of certifier

is of person who completed ceuse of deeth (Item 236 Type, Print) /AKON 32. Registrer's Signeture

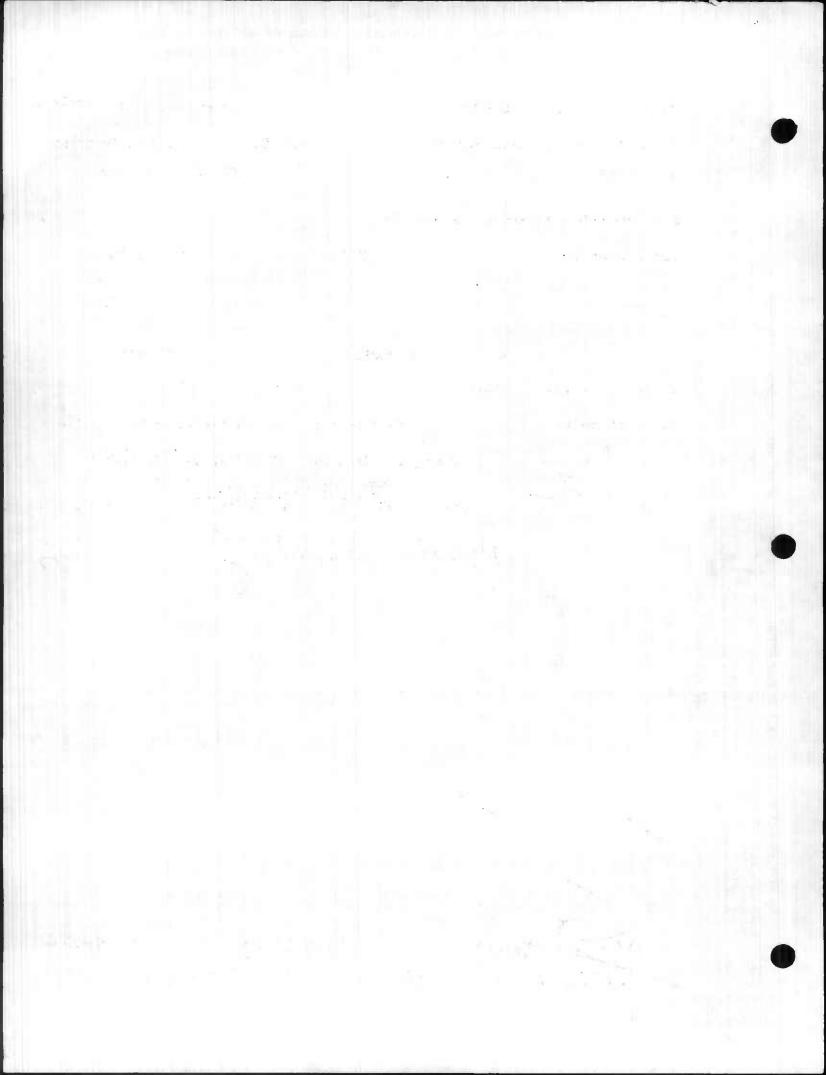
Darks

3001

Hospital Drive,

29c. License number

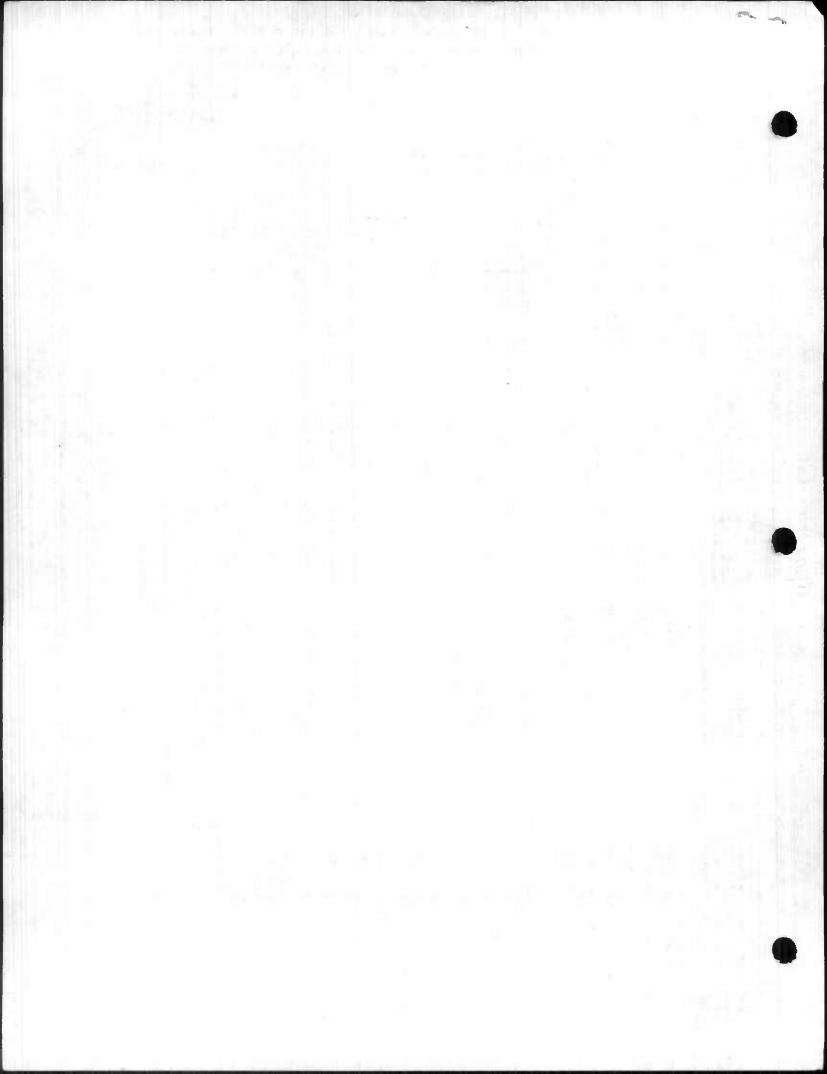
29d. Dete signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** /Medical cility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON If Under 24 Hrs. | B If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 10 M 20 F Yrs. Director 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or frame 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 Yas 2 No Funeral Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 No WYes, Giva Year or Dates: W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 Never Married 2 Married specity: While 1□ Yas 2No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Langston -Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. nnt: If Item 27 Ia marked other than ' ury or other treumstic avant, on Ma Elementary/Secondary (0-12) College (1-4or 5+) Maryland 17. Father's Name (First Middle Last. 18 Mother's Name (First Middle May Be 19a. Informant's Name/A 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) lationship (Type, Print) extsville 0 PP mportant: If Item 27 any Injury or other to Baitimore. Jan 15 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata Department 4 ☐ Donation 5 ☐ Other (Specify) Evans 21. Signature of Punaral Service Licenses Chapel 325 VORK Rd. 1/MON/1 the mode of dying, such as cardiac or respiratory errest IMONIUM art f. Entar the disease, or complications that caused the death. Do not enter hock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final 14 month disease or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Prance 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? page 2 s 1 Yas 2 No certificate Division of Vital or Attending Physicien: funaral director, 8 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Nother (Specify) +0501Ce Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 ANatural death. 1 TYes 2 No 2 Accident 24 hours efter deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) within 2 ş 29b. Signature and tha of pertifier 29c. License number 29d. Data signed (Month, Day, Year) 172797 ,2000 30. Nama and addrass of person who completed causa of death/(Item 23a) (Type, Print) Balks. md N. Chales Ce GBMC 6701 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 2000 oaks Registrar

DHMH 16 Rev 6/95

Ser



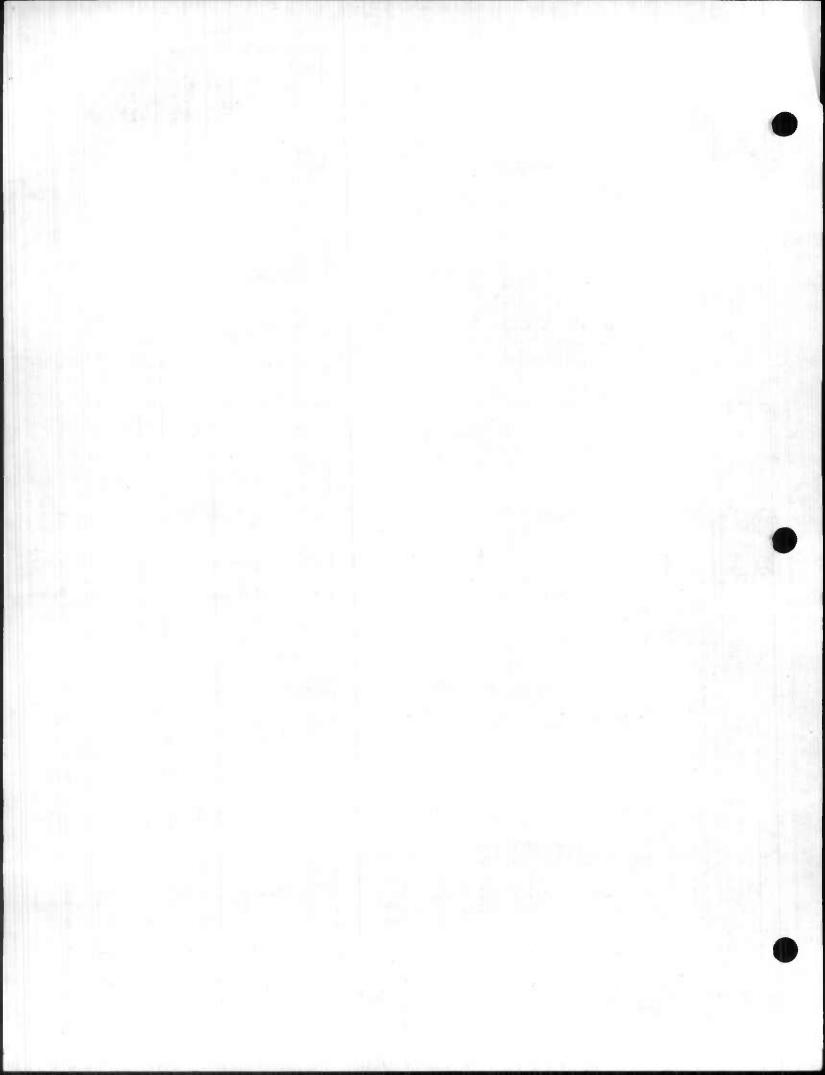
Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Fiorina Petrucci January 15 7:10am 2000 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3421 Claremont Street Baltimore Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7-15-1918 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1□M 210 F Yrs. 81 Director Philadelphia, Pa. 212-74-1112 Usual Rasidence of Decedant 10a State 10h County 10c. City, Town or Location 10d Inside City Limits MD n/a 1 XYes 2 No Baltimore Director 28a-f 10e Street and Number 10f Zin Code 10g. Citizen of What Country? mast be r 3421 Claremont Street 21224 USA Funeral flarms. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-tl Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian, Black, Whita, atc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 NWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Cottege (1-4or 5+) 3rd Home maker In own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fall ment of Health and Mental H tant: If hern 27 is marked oth lury or other traumatic aven 88 Antonio Tagliente Maria Pia Navarro 19a. Informent's Name/Relationship (Type, Print) Son 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 S. Highland Avenue, Baltimore, Md. Domenico Petrucci 21224 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 1/18/2000 Baltimore, Maryland 0aklawn 4 Donation 5 Other (Specify) Entomb. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224 4. Janner area 23a. Part1. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) WEEK Examiner Due to (or as e consequence ot) VLTIPLE The lew requires that the deeth certificate be assected the burial-transit Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pug Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): for usa as been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uss contribute to the causs of death? 1 ☐ Yes 2/1 No 3 Probably 4 Unknown HARRIC OBSTRUCTIVE PULHONARY DISEASE Records, p 24b. Ware sutopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? ONGETIVE HEART PALLURE page 2 1 ☐ Yes 200 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) edical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Neturat 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifian 29c. Licensa number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 2809 BOSTON ST BALTHONE MD 21224

State Registrar 4 32 Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Vear **Physician** 2000 orence /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Moskins Medica N/A Dayvieu STOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 20XF Hours 214-14-9552 Director 86 21 Maryland Usual Residence of Decedent death with the Maryland 10a. Siete 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow must be notified at 1 ☐ Yes 2 ☑ No Funeral Director 288-1 Dundalk Maryland Baltimore 10f. Zip Code 10e. Sireet and Number 10g. Citizen of What Country? 6 1818 Walnut Avenue 21222 United States 230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rems : 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. the Medical Examiner filed within 72 hours efter 1 ☐ Yes 2⊠ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 21215-0020 ò 1 Yes 2℃No Specify: Specify: þ White 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Years Homemaker Own Home Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental h Pages 1 and 2 should be nent of Health and Mental Howard Charles Bayne Kotie Kandel 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a: If item 27 is Patricia K. Nodonly (Daughter) 1818 Walnut Avenue Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremeiion 3 ☐ Removel from Stete 8 Department of Important: If any injury or Parkwood Cemetery 1/21/2000 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerei Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) erphrovascular Examiner Due to (or,as a consequence of): Examiner 40 The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence Box 68760, od ing Due to (pr as a consequence of): Physician/Medical the Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? peed completion of cause of death? certificate has 2 300 1 ☐ Yes 2 No Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpetient Certification: To 2 ER/Outpatient 3 DOA this funerel 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation death. 1 Tyes 2 □ No 2 Accident the or Attand efter death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours e Funeral C 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. Medical completely To the Within 2 29b. Signeture and 29c. License number 29d. Dete signed (Month, Day, Year) 51208 oferos Gest Horal address of person who completed cause of death (tem 23a) (Type, Print) V intrar's Signature Dungan >412e

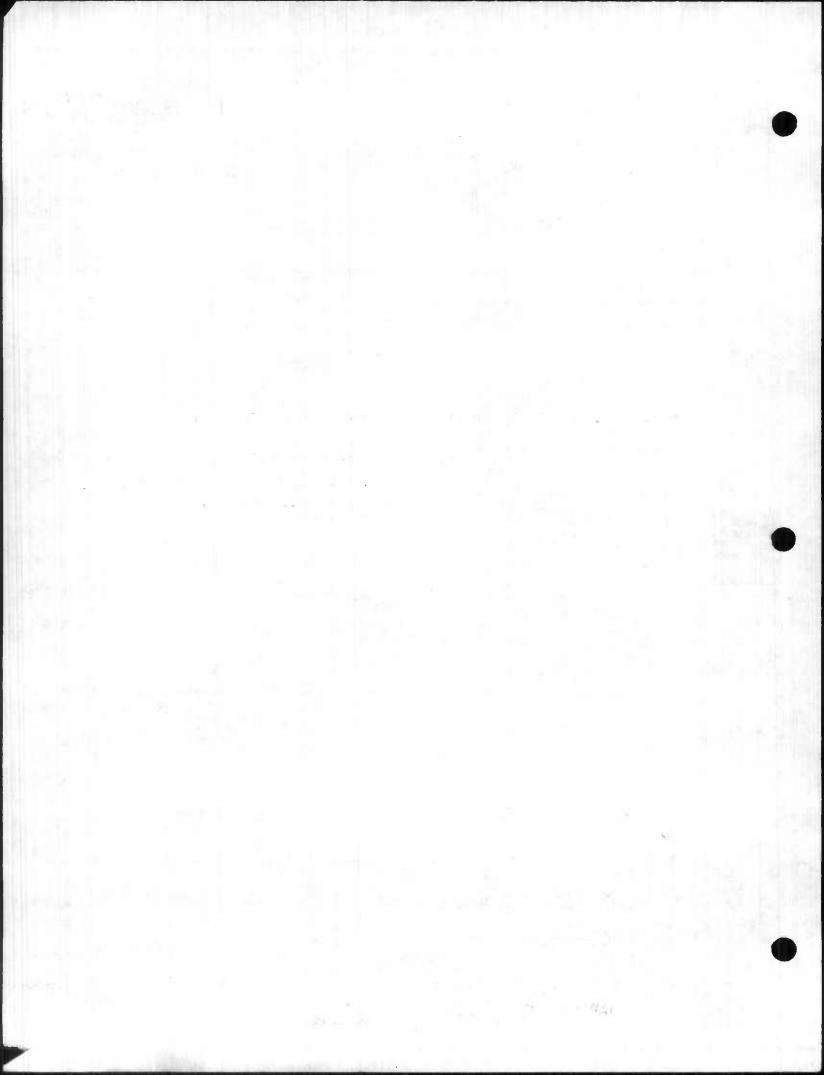
Registrar **DHMH 16 Rev 6/95**

State

Year)

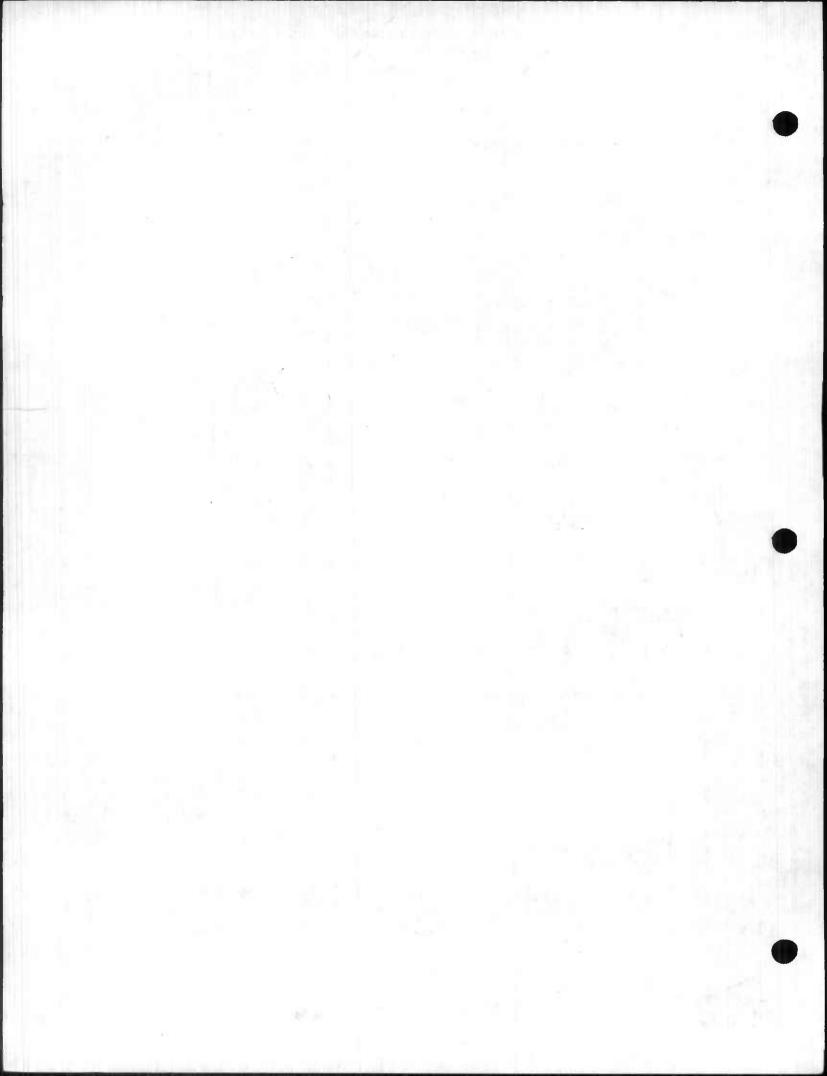
2000

32. Registrar



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

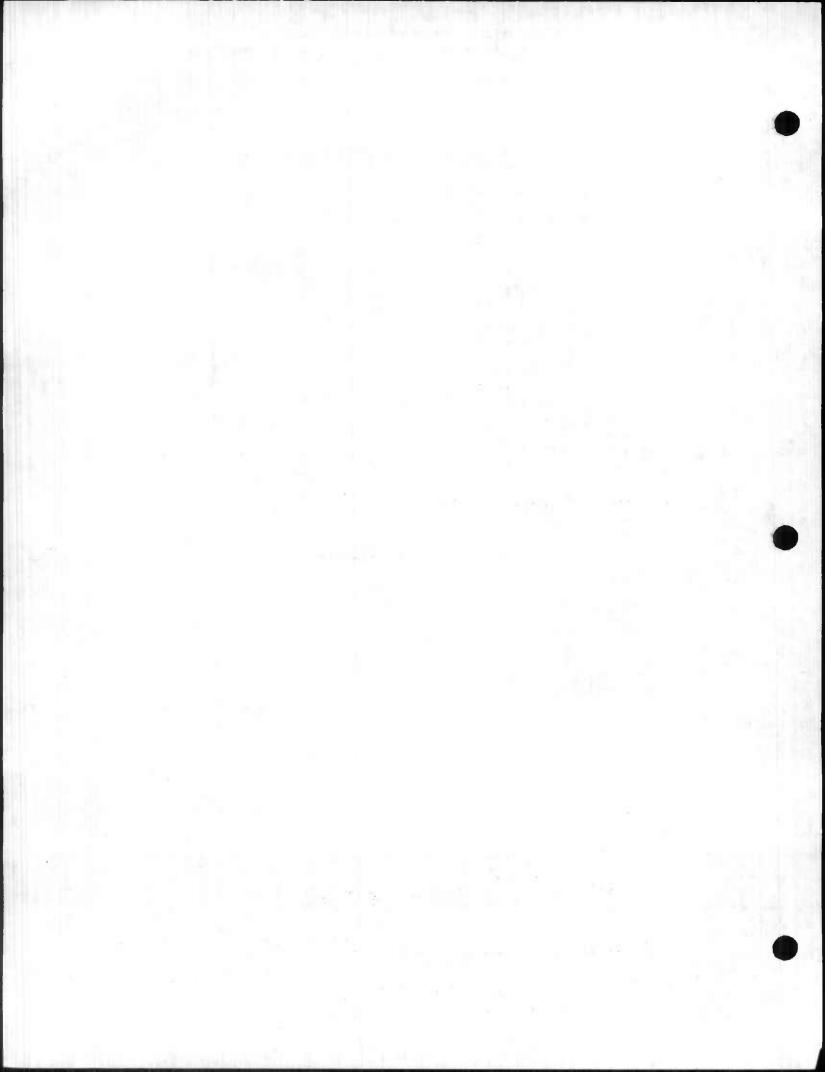
													Reg. No.			
Physician /Medical	1	ecedent's Nam	e (First, Middl	le, Last)	Edna	Virgin	ia Phel	Lps				2. Dete of Dec Month Januar	Dey	20	Year 000	3. Time of Death 12:35 P
Examiner	4 0 1	Facility Name (I	if not institution er Heal				ie			Glen	Bur		Ar		of Deeth Arun	
Funeral Director		ocial Security N 217 40	7743	6. Sex	M 2X F	7. Age (In yr. 84	s. last birthday, Yrs.	Months Months	Deys	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, De Feb. 13	y, Year) 3, 19	15		lace (State or Ford try) Cyland
ritems 23e or 28e-f show siner must be notified at Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Riviera Beach											0d. Inside City Lin 1 ☐ Yes 2X				
	100	10e. Street and Number 241 Carvel Road						10f. Zip Code 21122					10g. Citizen of What Country? U.S.			
, A	2 :	11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give Yeer or Dates:		Was Decedent of Hispenic Orlgin? (Specifi Yes, specify Cuban, Mexican, Puerto F			Rican, etc.)		4. Race - American Indien, Bleck, White, etc. Specify: White					
ygiene. Net than "natural", It, the Medical E. Completed by			15. Deceden	nt's Educ est grade	completed)	completed) (Gin		ecedant's Usual Occupation live kind of work done during most of working e. DO NOT use retired)			ing	16b. Kind	d of Bu	siness/Ind	lustry	
	17.	Elementary/Secondary (0-12) 7th 17. Father's Name (First, Middle, Last)		Last)	College (1-4or 5+)		Hor	Homemaker		18. Mother's Neme (First, Middla,		Own Home				
in and Mental 7 Is marked or traumatic svs To Be				John Meek		ek				Ida		la Mae		(not ava		ilable)
rtment of Health rtant: If Hem 27 njury or other tr	20a.	Edna Ke Method of Disp 1 Burial 2 4 Donation Signature Fu	position Cremetion 5 Other (S	3 □Re Specify)	emovel from	20b. Place of Disposition (Name of			1	Riviera Beach, Maryland 21 Dete 20c. Location - City or Town, Stete 1/18/00 Baltimore, Maryla Gonce Funeral Home P.A.			wn, Stete Maryland			
impo impo any li		Te	day	J.	M	ne						Gonce F y Balt				
ysician Medical	Imn	nediate Causa ((Final	complic tonly on			eth. Do not en					or raspiratory ar				Approximata Interval Batween Onset and Death
Medical and principle of the purint-transit and principle of the principle	Imm discress Sectification Cau Cau their resi	nediate Causa ((Final on onditions, namediate styling injury s	a.		Due to	eth. Do not en	equanca ot)	lor			-				Intarval Batween
attending physician and for use as the burial-fransit clarks as the burial-fransit clary. Slany, Medical Examiner	Imm discress	nediate Causa base or condition ulting in death) quentially list conduction y, leading to in se. Enter Unde use (Disease or initiated events ulting in death) in	(Final on onditions, minediate orlying injury s Last	a. b. c. d.		Due to	th. Do not en	equence of)	olor :	Ca	uru	or raspiratory at	4	Jee Cor	ntribute to	Intarval Batween
by the attending physician and a section of the attending physician and a section of the purish that it is not a section of the physician of t	Sectification Cautheliness	nediate Causa (pase or conditional ulting in death) quentially list con ny, leading to in se. Enter Unde se (Disease or initiated events	(Final on onditions, minediate orlying injury s Last	a. b. c. d.		Due to	th. Do not en	equence of)	olor :	Ca	uru	C M	4		antribute to	Intarval Batween Onset and Death An Krunw the cause of death
gred by the attending physician and be detached for use as the build-transit animal by Physician/Medical Examiner	Second cau Cau their rest	nediate Causa base or condition ulting in death) quentially list conduction y, leading to in se. Enter Unde use (Disease or initiated events ulting in death) in	(Final on onditions, minediate orlying injury s Last	a. b. c. d.		Due to	th. Do not en	equence of)	olor :	Ca	uru	23b. Did 1	dobacco u Yee 2] No	3 Prol	Intarval Batween Onset and Death An Krunw the cause of death
are has been signed by the attending physician and page 2 should be detached for use as the burial-transit ariginal page 2 should by Physician/Medical Examiner	Imm districts Section 1.	nediate Causa (asse or condition ulting in death) quentially list cony, leading to in see. Enter Unde see (Disease or initiated events ulting in death) II. Other signif	(Final on ditions, mediate ortying injury s Last	a. c. d.		Due to	th. Do not en	equence of)	olor :	ven in Pert	1.	23b. Did 1	tobacco u Yee 2 an autops med?] No	3 Prot	Interval Batween Onset and Death An Krunv The cause of death and Death 4 Punkr are autopsy finding illable prior to mpletion of cause
artificale has been signed by the attending physician and color, page 2 should be detached for use as the burial-transit animal and be Completed by Physician/Medical Examiner	Imm discrete from the first from the	nediate Causa (sase or conditional properties of conditional properties of cause of	(Final on onditions, mandate orlying linjury s Last	a. c. d.	tributing to d	Due to Due to	eth. Do not en	quence of):	cause gh	ven in Pert	I.	23b. Did 1 24a. Wes perio	an autops med?	No Sy	3 Prol	Interval Batween Onset and Death An Kourn The cause of death are autopsy finding illable prior to mpletion of cause death? Yes 2 No
h. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit an opposite the completed by Physician/Medical Examiner	Imm disk ress	nediate Causa (sass or condition ulting in death) quentially list control (sass and the	(Final on ditions, naved date entrying injury s Last	a. c. d. ons cont	ospitel: 1	Due to Due to	th. Do not en	equence of): quence of): quence of): quence of):	cause gives	ven in Pert	I. e ot Daal	23b. Did 1	an autops med? Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No No Otho	3 Proli	Interval Batween Onset and Death An Kourn The cause of death are autopsy finding illable prior to mpletion of cause death? Yes 2 No
h. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit an opposite the completed by Physician/Medical Examiner	Imm disk ress	nediate Causa (asse or condition ulting in death) tuentially list co ny, leading to in see. Enter Unde use (Disease or initiated evente ulting in death) II. Other signification Was casa refare examiner? 1 Yes 2 Manner of Deat	(Final on ditions, naved date entrying injury s Last	a. c. d. d. hit He	ospitel: 1 28a. Date (Mor	Due to Due to Due to Due to Inpatient 2: of Injury Year)	eth. Do not en	quence of): quence of): quence of): quence of): and all D ot M	cause given	ven in Pert	I. e ot Daal	23b. Did 1 24a. Wes perfo	an autopsimed? fes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No No Otho	3 Prol 24b. Will av. co of	Interval Batween Onset and Death An Kourn The cause of death are autopsy finding illable prior to mpletion of cause death? Yes 2 No
Furneral Director: After this certificate has been signed by the attending physician and black of the this certification, page 2 should be detached for use as the burial-transit or black filled in by the tuneral director, page 2 should be detached for use as the burial-transit or black filled in by the tuneral director, page 2 should be detached for use as the burial-transit or black filled in by the tuneral director. To Be Completed by Physician/Medical Examiner	Imm distriction of the second	was casa refarexaminer? II. Other signification of the way and the work of the way and th	(Final on ditions, mediate ordying injury s Last Ficant conditions of the medical of the medica	d. c. d. d. ons cont	ospitel: 28a. Date (Mor 28e. Plece build	Due to Due to Due to Due to Due to Inpatient 2! of Injury Ating, etc. (Special Special S	eth. Do not en 12 17 2 (or as e consa (or es a conse (or as a conse esulting in the or 28b. Time of Injury home, tarm, sicity)	quence of): quence of): quence of): quence of): quence of): thocurred thocurred	cause gh	ven in Pert 26. Place her: 4 No. iny at rik? I Yes 2	I. e of Daal ursing Ho	23b. Did 1 24a. Wes performent of the Check only of the Check onl	an autopsimed? fes 2 one) dence 6 now injury Street end vn, Stete) cause(s) 8	No No Other occurr	3 Prot 24b. Wi avi co of 1E er (Specifi red	Interval Batween Onset and Death An Kourw In the cause of death and Death and Death 4 Interval Batween Onset and Death 4 Interval Batween Onset and Death 9 Interval Batween Onset and Death 9 Interval Batween Onset and Death 9 Interval Batween Onset Batw
is aner death. It is aner death. It is a first this certificate has been signed by the attending physician and in the time that the timester, page 2 should be detached for use as the burishtransit in the timester. Certification: To Be Completed by Physician/Medical Examiner	Imm districts Section 1 and 1	was casa reference of Death United the Causa (puentially list control only, leading to insection of the Cause (Disease or initialed eventialing in death) Was casa reference of Death Countries	(Final on Moditions, nonditions, nonditions, nonditions, nonditions, nonditions, nonditions, nonditions) Figure 1	d. c. d. ons cont ng gation not be nined fexamin	ospitel: 28a. Date (Mor 28e. Plece build	Due to Due to Due to Due to Due to Inpatient 2: of Injury th, Day Year) a of Injury - At ing, etc. (Special Special Speci	eth. Do not en 12 17 2 (or as e consa (or es a conse (or as a conse esulting in the or 28b. Time of Injury home, tarm, sicity)	quence of) quence of): quence	cause gh	ven in Pert 26. Place her: 4 No. iny at rik? I Yes 2	I. e of Daal ursing Ho	23b. Did 1 24a. Wes performent of the (Check only come 5 Residence 28d. Describe 1 28f. Location (City or Town	an autops med? (es 2 one) dence 6 now injury Street end wn, Stete) cause(s) a data and j	No N	24b. Windows and a second of the second of t	Interval Batween Onset and Death An Kourw In the cause of death and Death and Death 4 Interval Batween Onset and Death 4 Interval Batween Onset and Death 9 Interval Batween Onset and Death 9 Interval Batween Onset and Death 9 Interval Batween Onset Batw



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	1	1	0	1
0		1	6	0

	1. Decedent'a Name (First, Middle, I	Last)	U	ertificate of	Deall	2. Date of Deat	ig. No.	3. Tima of Dea			
hysician /Medical	a land to the land	John Anthony Petrecca Jr.									
	4a Fecility Nama (If not institution, g		nong reor	July 1	4b. City, Town, or	January Location of Death	4c. County o	000 4:10 P.			
xaminer	103 Phelps Ave			4.0	Glen Bu			Arundel			
eral		Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Year			Voer)	Birthplace (State or Fo Country)			
tor	217 40 7891 Usual Residence of Decedent	1 Ø M 2□F	56 Yrs.	Months Days	Hours Mir	Feb. 10	1943	Maryland			
or items 23a or 23a-f show miner must be notified at Puneral Director	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Li			
	Maryland Anne	Arundel	Glen Bu	ırnie				1 ☐ Yes 21			
	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Country?			
	103 Phelps Aver	nue		210	60		U.S.				
	11. Marital Status	12. Was Decedent	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify (Specify Yas or No-	14. Race	- American Indian,			
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 17 Yas 2 □ 1	√o Viet Nam	1 ☐ Yas 2 🕱 No		no Alcan, etc./	Black, White, etc. Specify: White				
		Education	16a De	cedent's Usual Occu	pation		16b. Kind of Bus	iness/Industry			
Completed	(Specify only highast of Elementary/Secondary (0-12)					orking					
E	Lionisinally bookings. y (6 12)	2 years		arber			Hair	Dressing			
Be	17. Fathar's Nama (First, Middla, La	st)				eme (First, Middle, M					
20		John A. Pet	trecca Sr	•	I	Elizabeth	Jane Ha	11			
	19a. Informant's Name/Relationship			ailing Addrass (Stree	et and Number or F	Rural Route Number,					
	Paula J. Petrec	ca / Wife	e 103	Phelps A	venue	Glen Burn	nie, Mar	cyland 21060			
	20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3	□ Domovel from State	20b. Plece of Dis cemetery, o	sposition (Name of rematory or other pl	ace)	Date 2	20c. Location - C	City or Town, State			
	4 Donation 5 Other (Spec		Sacred	Heart of	Jesus	1/18/00	Baltimo	re, Marylan			
d d	21. Signature of Funaral Servica Lic	ansee	0	22. Nama and Addr	ess of Facility	Gonce Fi	neral F	Home P.A.			
8	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225										
	B IIVIGO II CAPAINO POR CAPA										
an	23a Part. Enter the disease, as cardiac or respiratory arrest, Approximate shock, or heart failura. It also on one cause on each line. Approximate Interval Betwee Onset and Dea										
al	Immediate Cause (Final										
r	disease or condition resulting in death)										
ا ا	Due to (or as a consequence of):										
edical Examiner	Sequentially list conditions Due to (or as a consequence of):										
Ä	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.										
Ca	that initiated events	that initiated events									
	resuming in death) cast										
ar/		d									
10	Part II. Other significant conditions	23b. Did to	Did tobacco use contribute to the cause of de								
Phy		1 🗆 Ye	1 Yes 20 No 3 Probably 4 Unk								
by											
8						24a. Was an		24b. Were autopsy findi available prior to			
Be Completed by Physician/M								completion of caus of death?			
EO						1 🗆 Ye	s 2000	1 ☐ Yea 2 ☐ No			
3e C	25. Was case refarred to medical				26. Place of De	eeth (Check only on	e)				
0	examinar?	Hospitel:	nt 2□ER/Outpa	tient 3 DOA	ther	Home 5 Reside	-	r (Specity)			
Medical Certification: To Be Com	27. Manner of Death	28a. Dete of Inju	28a. Dete of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?								
	1 Prolatural 5 Pending investiget	ion	(Month, Day Year) Injury Work? M 1 Yes 2 No								
tiffe	3 Suicide 6 Could not determine	288. Place of Inj	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)					Location (Street and Number or Rural Route Number, City or Town, State)			
Cen		Duraning, Gir	(0,000,00)								
dical	29a. Certifier 1 Certifying (Check only one)	Phyeician: To the best sminer: On the basis of end manner at	examination and/or	ath occurred at the investigation, in my	time, dete and place opinion, daath occ	ce, and due to the co curred at the time, de	tuae(s) and mar ete and pleca, a	nner as stated. nd due to the cause(s)			
Ž	29b. Signatura and titla of certifier		11-52	29c. Licar	nsa number	2	9d. Date signed	(Month, Day, Year)			
	Inact	6 -			2011	/	1/12	100			
	Jonestan	1- omn	n, Mil		4700		111	100			
>	30. Name and address of person wh	20			- /	La Bore		un 2/06/			
-	Jona Man	Il'man		40635,C	rum 4	ren 1/000	ne 1	10 -100			
State	31. Data filed (Month, Day, Year)	2000	ar'a Signature	4 los	No.						
strar											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 16, 2000 DORA PLASSE 9:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12428 GARRISON FOREST ROAD OWINGS MILLS BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□ M 20 F 071-28-1481 85 Director SEP. 6, 1914 Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Director PALM BEACH BOCA RATON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7209 PROMENADE DRIVE #302 33433 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify: WHITE Specify: à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 98 **ABRAHAM** ROTNER ANNA LEWIS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROME PLASSE / SON 12428 GARRISON FOREST ROAD - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State MT. HEBRON CEMETERY 1/18/2000 QUEENS, NEW YORK 4 Donation 5 Other (Specify) 21. Signature of Paneral Service Lie 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 234. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel vascular Vistan disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SON S HOME 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.

The law requires that the death certificate be assouted Box 68760, P.O. Records, Division of Vitai Attending Physician:

the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0020

28e-f

b mart be

ò

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

nt of Health a if flam 27 is or other tra

burial-transit

the

USE 25

à

ata has been signed page 2 should be de

certificata

this

funeral director.

To the Hospital or Attanding within 24 hours efter death.

To the Funeral Director: Aft completely filled in by the fur

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19550

Iluose 70

M.1)

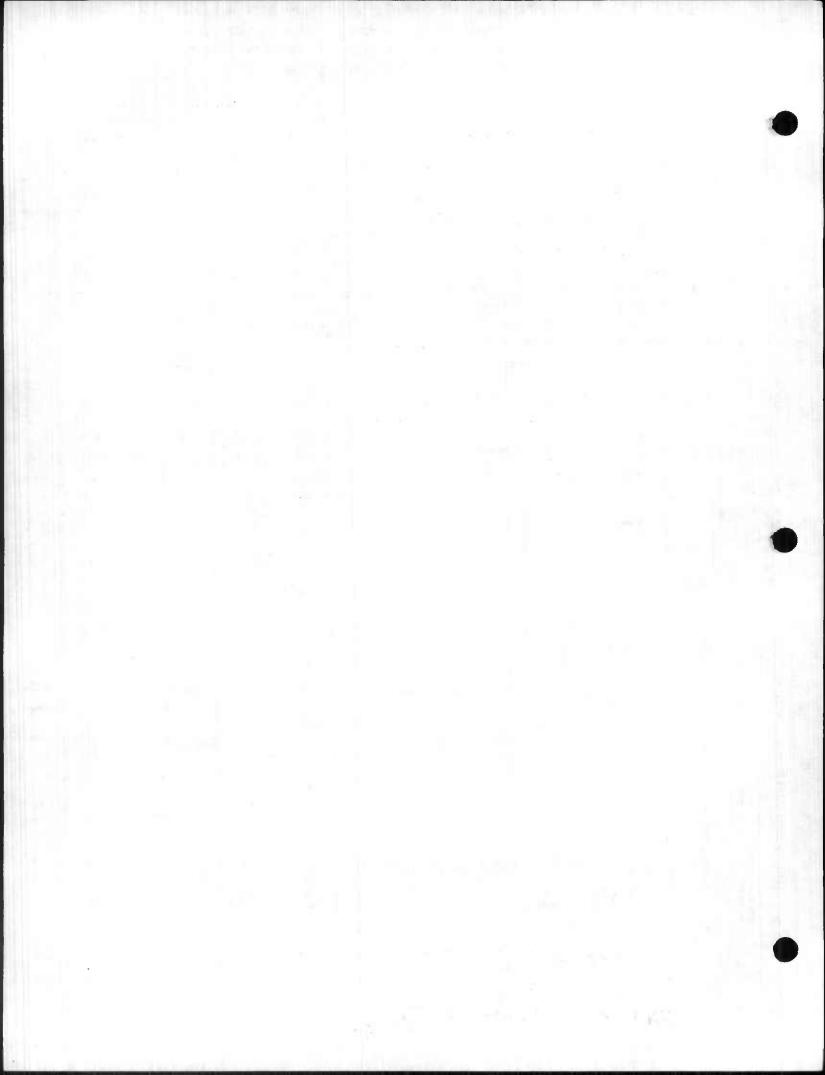
32. Registrar's Signature

10085

29c. License number

Red Run Blud. Owings

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth , 2000 JANUARY 7:15 4-17. Victoria Reesey 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not Institution, give street and number) BALTINOLR FRANKLIN SQUARE HOSPITAL RUSEDALR CENTRA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 10 M 25 F Months 219-76-9715 Nov. 19, 1958 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7314 Martell Avenue 21222 United States 12. Wea Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 2 Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Stetua 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) G.E.D. Home Maker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Robert Carvel Reesey Martha Wolinski 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion L. Reesey Stepmother 3 Loughmask Court #301 Timonium, Maryland 21093 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location · City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Hilltop Service Corp. 1/17/2000 Towson, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. ofine 7922 Wise Avenue Baltimore, Maryland 21222 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) SEPSIS 2 HOURS BACTERENIA Due to (or ea a consequence of): Sequentially liat conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Laat PNEUNOPIA 3 WEEKS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10a State

Funeral

Director

notified

re 23a or i therms 23a

"natural", or Itan idical Examiner 72 hours after

the Maryland

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

filled within Hygiens. Wer then wert, the Me

Pages 1 and 2 should be nemt of Health and Mental 7

them 27 is other tra

三百 Department of Important: If any Injury or

> Examiner buriel-transit Physician/Medical 980 þ Completed page 2 funeral director, Be Certification: To

The law requires that the death certificate be executed physician the burial certificate has or Attending Physician: this After

within 24 hours after death. To the Funeral Director: A filled in by Hospital completely 2 6

State

edicai

29b. Signature and min of certifier

1 Yes 2 No

27. Menner of Deat

1 Netural 2 Accident

3 Suicide

29e. Certifier

4 ☐ Homloide

(Check only one)

5 Pending investigation

6 Could not be determined 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

1 Dinpatient

Hospital:

28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number of Rurel Route Number, City of Town, State)

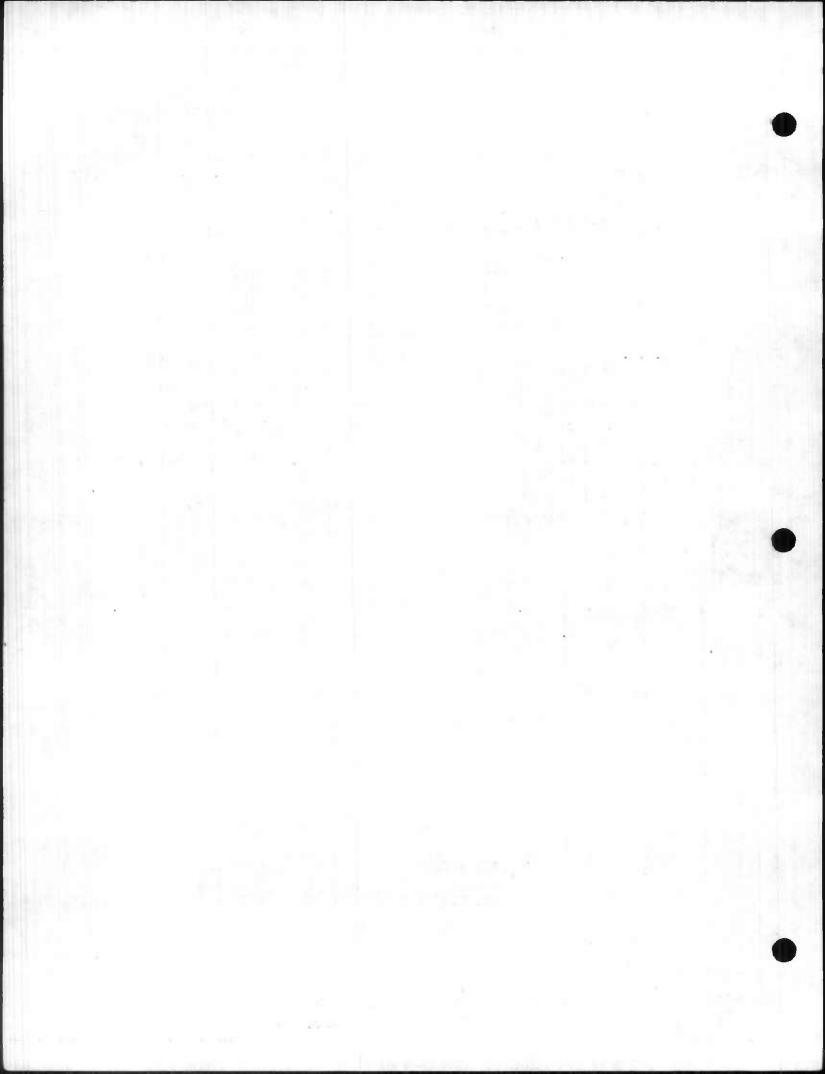
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted. 29d. Dete signed (Month, Dey, Year)

196418

30. Neme and address of person who por pleted cause of death (Item 23a) (Type, Print)

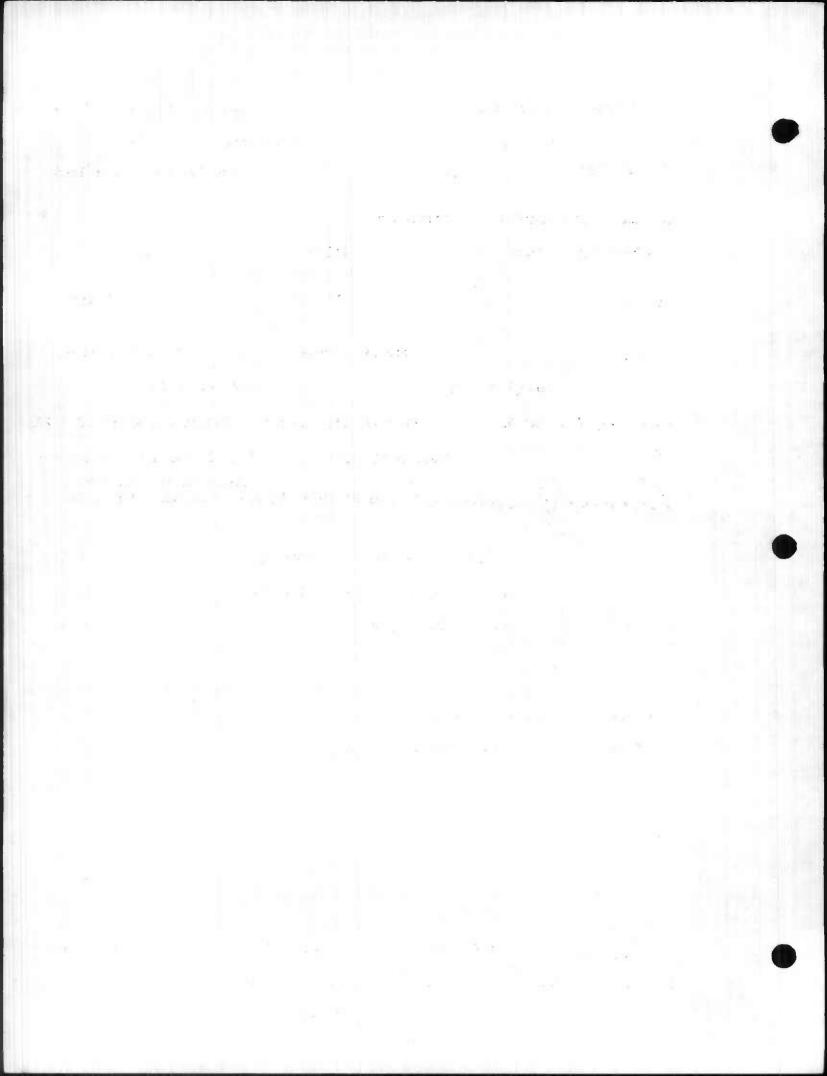
FRANKLIK SQUARE DR. BALTO, ND 21237 FORSYTHE MD 9000 ALLRY 31. Date filed (Month, Day, Year) Registrar's ignature 9

Registrar



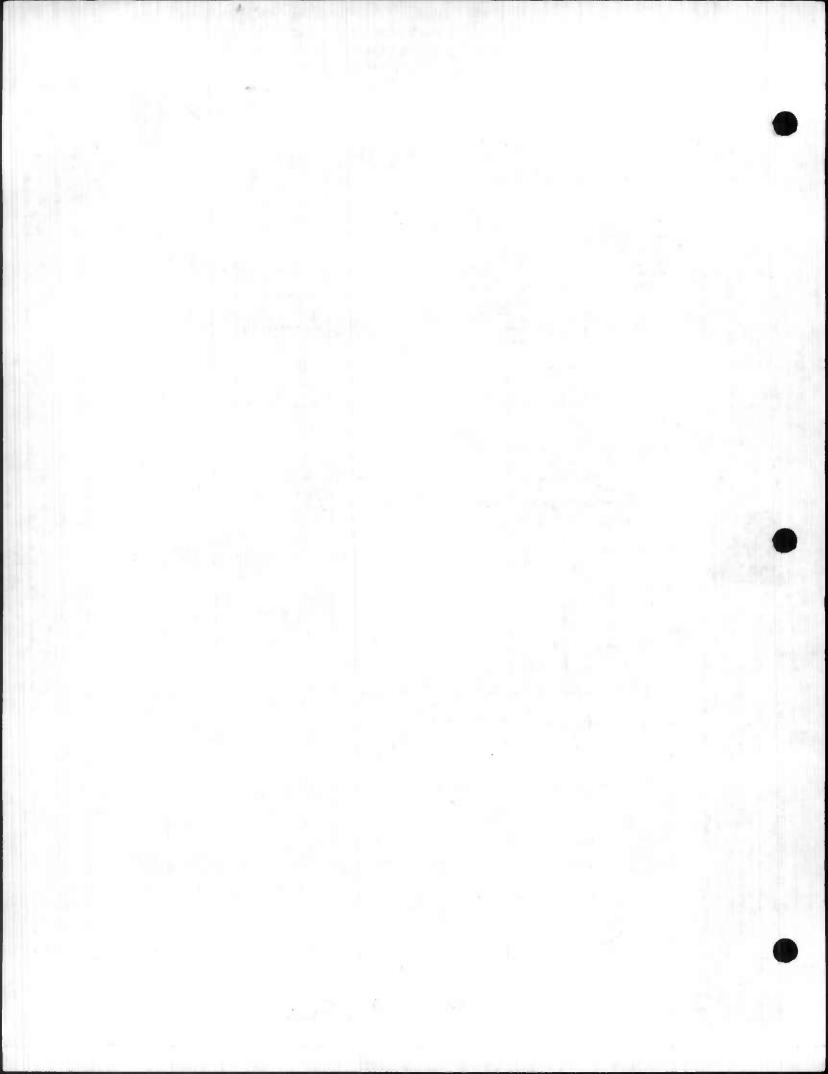
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Yaar **Physician** NORMAN RAY SR. , 2000 12:40 A.M. JANUARY 17 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
June 12, 1908 9. Birthplaca (Stata or Foreign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax **Funeral** 1XM 2□ F Months Days 212 07 8380 91 Yrs. Maryland Director Usual Rasidance of Dacedant death with the Maryland 10c. City, Town or Location 10h County 10d. Insida City Limits r 28a-f show notified at 1 ☐ Yas 2 X No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "naturel", or items 23a or adical Examiner must be a 109 West 11th Avenue 21225 U.S. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental hygiene. nt: if item 27 is marked other than "natural", or iten iny or other traumatic event, in Mental Exammer iny or other traumatic event, in Mental Exammer 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify. g White 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15 Dacedant's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Window Trimmer Reads Drug Store 8th 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Laura V. Upton Joseph W. Ray 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Norman Ray Jr. 300 West 11th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. 1/19/00 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Daath **Physician** /Medical Immediata Causa (Final RESPIRATORY 1 days disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner DISTRESS SYNDROME RESPIRATORY and I-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting In death) Last Dua to (or as a consequence of) physician a Box 68760. ACUTE PNEMONIA Physician/Medicai Dua to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown MEART FAILURE CONGESTIVE Division of Vital Records. à 24b. Wara autopsy findings available prior to completion of cause 24a. Was an autoosy Completed · REMAL FAILURE MITH MYPERKALEMIA certificate has birector, page 2 s 1 Yas 2 No 1 Yas 2 No Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No Certification: To 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 2 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifiat edical 29d. Data signed (Month. Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number 13472 m.D. JANUARY 17,2000 aulan 30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print) BACTIMORS SANDEEL HOSPIAL, HARBOR 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 3 0

			Cert	ificate of	Death	Re	g. No.				
	1. Decedent's Neme (First, Middle, Last)					2. Date of Deat Month		3. Time of Death			
Physician /Medical	FRANCES RIK	ER				JANUA		2000 835/PI			
Examiner	4s Facility Name (If not institution, give st	reet and number)			4b. City, Town, o	Location of Deeth	4c. County of				
	STELLA MARIS HOSPI	CE AT MERCY			BALTI		ı	N/A			
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. ias		If Under 1 Year Months Days			Year)	Birthplece (State or Foreign Country)			
Director	218-28-0980	8	33 Yrs.			May 7,19	916	W. VIRGINIA			
Pug &	Usual Residence of Decedent 10a. State 10b. County	10c City 1	Town or Loca	ation				10d. Inside City Limits			
ahow det			TIMORI					1 No Yes 2 No			
vith the Mar t or 28e-f all be notified Director	MD. N/A	DAL			- Aw 444m						
# 0 M	10e. Street and Number			10f. Zip Code		19	g. Citizen of Wh				
era est	2241 EASTERN AVE	NU E . Wes Decedent Ever in U.S.	T 40 W		231	Constitution of the	U.S.A	- American Indien,			
5-0020 72 hours after death with the Maryland netural; or thems 23s or 28s-f show deat Examiner must be notified at	11. Marital Stetus 1 Never Merried 2 Merried 3XWidowed 4 Divorced	Armed Forces? 1 Yes 2 (No If Yes, Give		Yes, specify Cub		Specify Yes or No- irto Rican, etc.)		, White, etc.			
within 72 hours of gions. If then "netural", or the "netural", or the Model Exempted by [Year or Dates:						WHITE			
nation of the	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Decede (Give ki	nt's Usual Occu ind of work done	pation during most of w d)	orking	16b. Kind of Busi	ness/Industry			
flied within 72 ho Hygiens. ther than "naturn int, the Modest	Elementery/Secondary (0-12)	College (1-4or 5+)			0)		CLOTUS	NO			
	17. Father's Neme (First, Middle, Last)		SEA	MSTRESS	18. Mother's N	ame (First, Middle, N	CLOTHI				
A S O O											
d 2 should be the and Mental T is marked or traumate average To Be	EDWARD SHEPPARD 19a. Informent's Neme/Relationship (Type	Print	10b 84cm	Address /Os		AN ANN LOV Bural Route Number,		Vata Zin Codal			
d 2 s											
f Haalth fram 27 other tr	SUSAN WARD / DAUGHTE			WILKENS tion (Name of	AVENUE,	BALTIMORE.		D 21223 lity or Town, Stete			
5 5 5 5	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rec	noval from Stete	etery, creme	story or other pla							
pemit. Pag Department important: It any Injury o	4 Donation 5 Other (Specify)	GREE		T CEMETI		(17/00 E	BALTIMOR	E, MARYLAND			
Pemit. Departimental importal eny inju	21. Signature of Funeral Service Licensee	1		Name end Addre		FILMEDAL	FUNERAL HOME				
40240	23a. Part1. Enter the disease, or complice shock, or heart latture. List only one	A Cherol	19	O1 FASTE	ERN AVENI	IF BALTIMO	DE MD	21231			
law requires that the death certificate be amouted as been signed by the attending physician and a 2 should be detached for use as the burial-transit apleted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or es e consequence of): Due to (or es e consequence of):										
ulras that the death certification is signed by the attending id be detected for use a discovery by sician/M	Part II. Other significant conditions contri	buting to death but not resulting		3b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Vinknown							
v requires the been signed should be deleted by	Paris land	ast full	24a. Was er	fas en autopsy 24b. Were autopsy tinding evailable prior to							
	Moderatinal O	1□ Ye	completion of cause of death?								
ician: The cartificate rector, pa	25. Was case referred to medical	mog wire			MARIS AT MEA						
Physician: rible cartificital director, rai director,	examiner? 1 Yes 2 No										
ding Physics. After this infuneral di	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation		a 5 Residence (Control (Specify) HOSP CE 8d. Describe how injury occurred								
tal or Attanding P is after death. at Director: Attact and in by the funeri Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hooptel or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 - Certifying Physic (Check only one)	ian: To the best of my knowle r: On the basis of examination and manner stated.	dge, death o and/or inve	occurred at the ti stigation, in my	me, date end plac opinion, death occ	e, and due to the ca curred at the time, da	use(s) and meni ite and place, an	ner as stated. Id due to the cause(s)			
of the complete of the complet	29b. Signature and the of certifier	25	d. Date signed	(Month, Dey, Year)							
F > F 0	1 200 lh	-	141/100	1 12							
	20 Name and address of several	plotted course of death from the	20) /7:: 5		0854	V)	young	1 12,2000			
_	30. Name and address of person who com	- 201	Sal (Type, Pi	Davik ,	PI	RAK	L'man	¥ 13,2000 E MD 2/20			
State	31. Date tiled (Month, Day, Year)	732. Regtiling 9 Squatur		null	,	UMI	MINIOR	~ 1110 4/20			
Registrar	JAN 1 9 2000	100	/	O. Ap	ach						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month WALTER ROBINSON January 2000 11:02 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) ₩ 2 F Months Days Hours Min Yrs. 218-30-6836 63 3-22-36 S.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No FAYETTE FAIRBURN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 175 MONTICELLO WAY 30213 USA 12. Was Decedant Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12--4-STATISTICAL MANAGER U.S. POSTAL 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) GARLAND LOUDEN ELSIE B. ROBINSON

20b. Piaca of Disposition (Neme of cemetery, cremetory or other place)

DRUID RIDGE CEMETERY

Saddle embolus of main pulmonary artery

234 Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequenca of)

Pages 1 and 2 should be filled within 72 hours after death with the Meryland nent of Health and Mental Hygiene. 7 is marked other than "natural", or Nems 23a or 28a-f shot traumatic event, the Modical Examinal must be notified at Robinson, Walter 27 item 2 Department of important: If it any injury or one once.

> **Physician** /Medical Examiner

physician and s the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 for use as 1 the signed by the should i certificate has lirector, page 2 : Attending Physician: director. this funeral After To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death.

Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. Rhabdomyolysis

19a. Informant's Name/Relationship (Type, Print) EDNA ROBINSON (WIFE)

1X Buriai 2 ☐ Cremation 3 ☐ Removal from State

5 Othar (Specify)

to of Funeral Service Licensee

20a. Method of Disposition

4 ☐ Donation

Examiner Physician/Medical by Completed 86 Certification: To

Physician

/Medical

Examiner

10a. State

Directo

Funeral

Q

Completed

Funeral

Director

25. Was case referred to medical examiner? 1 Yes 2X No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 X Naturai 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29b. Signature and titla of cartifier

1 inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

29c. Licansa number 29d. Data signed (Month, Day, Year) D28885

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda)

175 MONTICELLO WAY FAIRBURN, GEORGIA 30213

22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard L. Siegel, M.D.

6701 N. Charles Street Baltimore, MD 21204

29a, Certifier

31. Date filed (Month, Dey, Year) JAN 1 9 2000

Greater Baltimore Medical Center 32. Registrar's Signature

28c. Injury at Work?

1 Yes 2 No

State Registrar

edical

DHMH 16 Rev 6/95

Approximate Interval Batween Onset and Death

Terminal

23b. Did tobecco use contribute to the cause of death? 3 Probably 4 N Unknown 1 Tyss 2 No

20c. Location - City or Town, State

1-21-2000 BALTIMORE, MARYLAND

24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of cause of death?

1 X Yes 2 No

26. Place of Death (Check only one)

1X Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

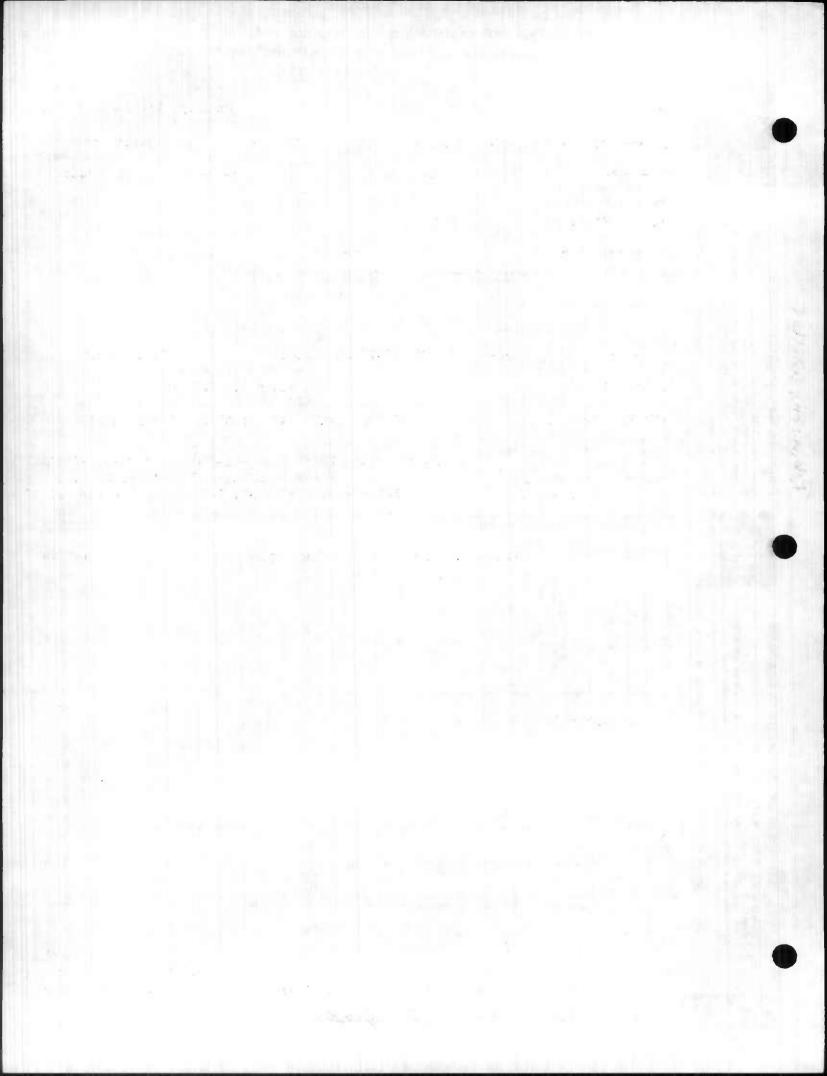
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

January 18, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death JANUARY 15, 2000 ROCHELLE RUBIN 3:00 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death LEVINDALE BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 6, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 20XF Months Deys Hours 212-03-8517 81 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A TY Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE #115 21215 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedenf of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER SHEPHERD ELECTRIC CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) LOUIS RUBIN ZELDA **BOUR** 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIETT LAFFERMAN / SISTER 6317 PARK HEIGHTS AVE. #115 - BALTIMORE, MD 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) OHEL YAAKOV BETH ISRAEL 1/17/00 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Kemole 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Cance 1□ Yes 2 2 No 1 □ Yas 2 □ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitef: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpafienf 3 DOA 28a. Date of Injury (Month, Day Year) 27. Margner of Dus 28d. Describe how injury occurred 28c. Injury at Work? 14 Inlatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide

Physician /Medical Examiner

pemit. Peges Department of Important: If it eny injury or o

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

B

Funeral

Director

the Meryland

Peges 1 and 2 should be filed within 72 hours effer death with the Menden neat of Heelih and Mentel Hyglene.
and if from 27 is marked other than "natural", or from 23a or 28a-1 show any or other than "natural", or from 25 and 25 and

21215-0020

Baitimore, Maryland

Physician/Medical Examiner þ Completed Be Certification: To

ettending physician and for use as the burlel-transit The lew requires that the deeth certificate be executed Box 68760. P.O. Division of Vital Records. 904 or Attending Physician: this . funeral After efter death. 5

filled in by Hospital within 24 hours To the Funeral (completely

> State Registrar

DHMH 16 Rev 6/95

Medical

31. Date filed (Month, Day, Year) JAN 1 9-2000

29b. Signature and title of certifier

4 ☐ Homicide

(Check only

29a. Certifier

mand address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signeture

m

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated.

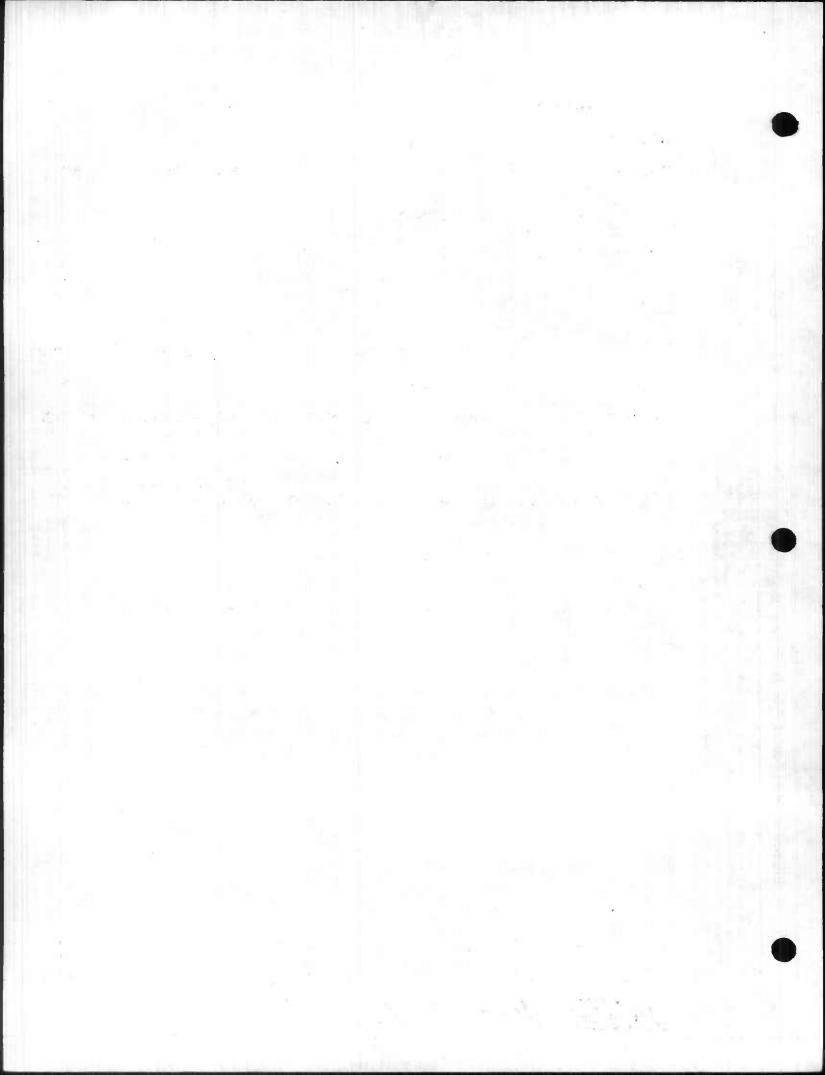
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and martner stated.

29c. License number

29d. Date signed, (Month, Dey, Year)

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

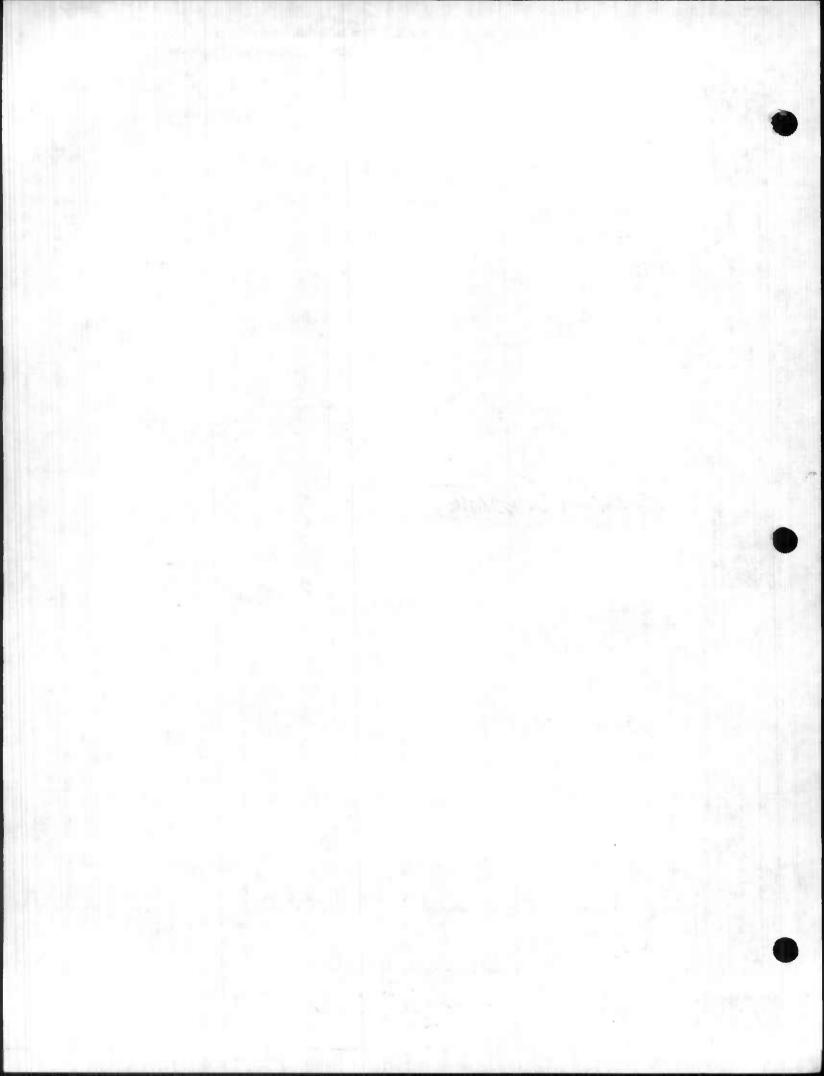
ORIGINAL



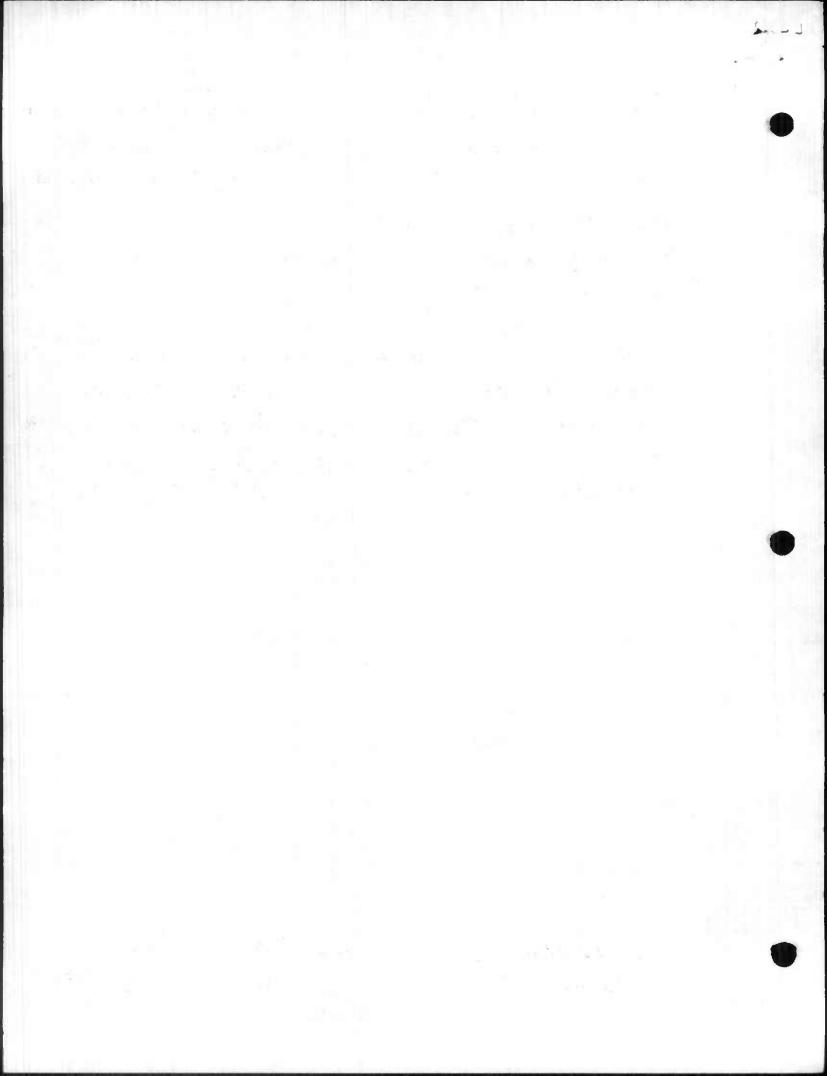
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11133

	I. Decedent a run	me (First, Middle,	, Last)							2	Date of De	eath		3. Time of Death	
ysician		,		Claren	ce W	illiam	Sha	ffer.	Jr.		Month	Day	Yeer	0500 AM	
Medical	4a Facility Neme	(If not institution							b. City, Town,	or Local	JAN.	6, 200) () tv of Death		
aminer									BALTI						
lowel l	5. Social Security	Number	SON STE		(In yrs. k	ast birthday)	If Unde	er 1 Yeer	If Under 24	Hrs. 8.	Date of Bir	th		place (State or Foreign	
Funeral Director	214-38- Usuel Residence	-4919	XIXIXM SE		59	Yrs.	Months	Days	Hours	Ain.	(Month, Da Jan 21	, 1941	Bal	to, MD	
11	10a. State	10b. County			10c. City	, Town or Lo	cation							10d. fnside City Limits	
edical Examiner must be notified at letted by Funeral Director	Md		N/A		Balt	imor	e						1 ₩ X 9 2 □ No		
be notified Director	10e. Street and N	lumber			_		10f. Zi	p Code				10g. Citizen of	What Cou	ntry?	
a de	5 N. k	resson :	Street					21224	1			U.S.A.			
iner must Funeral	11. Maritai Stetus		12. Wes	s Decedent E	ver in U,	S. 13. V	Vas Dece	edent of Hi	ispanic Origin	? (Specif	y Yes or No		ce - Ameri		
by Fu		arried 2 Marrie	ed 1 If Ye	1 Tyes 200 100			∏ Yes		Specify:	00101110	an, 010.j	Specify: White			
pet	10-	15. Decedent's	's Education	for a set	T	16a. Deced	ent's Usu	uai Occupi	ation			16b. Kind of	Business/In	ndustry	
ple	Elementary/Se	ecify only highest condary (0-12)	1	lege (1-4or 5+	b)				must of	working					
Completed	6th					Dryw	alle	r						ruction	
eg Be	17. Father's Nam	e (First, Middle, L											me)		
10		nce W. SI													
		Name/Relationsh											n, State, Zi	p Code)	
		Jacobs (Sister)	100L 5				le Ave.					our State	
	20a. Method of D	2 Octomation	3 □Removal	□ Removal from State				y or other place)							
	4 Donetion	o 5 ☐ Other (Sp	ecify)		Bal	to-Was				1/	14	Laurel	, MD	200	
*500	21, Signatura of	Funeral Servige L	Josephon	/ -	1	Bu	rgee	-Hens	ss of Facility	z Fu	neral	Home,	Inc.		
ysician Medical aminer	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest. Approximate finterval Between Onset end Death														
		eart failure. List d	only one cause	e on each line	θ.	. Do not ente		de of dyin			espiretory e	rrest,		Interval Between	
ical	Immediate Caus disease or condi resulting in death	eart failure. List o e (Final tion	only one cause	e on each line Ather	e. Vosek	ershic	Car	diove			espiretory e	rrest,		Interval Between	
ner	Immediate Caus disease or condi resulting in death	eart failure. List o e (Final tion	only one cause	e on each line Ather	e. Vosek	. Do not ente	Car	diove			espiretory e	rrest,		Interval Between	
examiner Examiner	Immediate Caus disease or condi resulting in death	eart failure. Cist of e (Final tion n)	only one cause	Ather	e. ならしん Due to (or	ershic	Car uence of)	de of dyin			espiretory e	rrest,		Interval Between	
edical Examiner	Immediate Caus disease or condi resulting in death	e (Final tion) conditions, immediate derlying or Injury nits	only one cause	Ather	Oue to (or	Prefic	Car uence of)	de of dyin			espiretory e	rrest,		Interval Between	
edical Examiner	immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death	e (Final tion) conditions, immediate derlying or Injury nits	only one cause	Ather	Oue to (or	ershic ras a conseq ras a conseq	Car uence of)	de of dyin			espiretory e	rrest,		Interval Between	
s the bunaturansit and transit	immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death	e (Final tition) conditions, immediate derlying or lajury nts	a	Ather	Due to (or	as a consequence as a c	Car uence of) uence of)	diove	ascula		Disea	(SC)	contribute	Interval Between Onset end Death	
edicai Examiner	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ever resulting in death Part II. Other eight	e (Final tition) conditions, immediate derlying or lajury nts	a b d	AHLLE	Due to (or Due to (or to not resu	as a consequence as a c	Car uence of) uence of)	diove	ascula		Da Sea	tobacco uee c		Interval Between Onset end Death	
by Physician/Medical Examiner	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter University Chisease that initiated ever resulting in death Part II. Other eight	e (Final tion) conditions, immediate derlying or Injury nits	a b d	AHLLE	Due to (or Due to (or to not resu	as a consequence as a c	Car uence of) uence of)	diove	ascula		23b. Did	tobacco use o	yeer OOO ounty of Death I/A 9. Birthplace (State Country) Balto, M 10d. Inside 11 Inside 12 In	Interval Between Onset end Death to the cause of death?	
by Physician/Medical Examiner	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter University Chisease that initiated ever resulting in death Part II. Other eight	e (Final tion) conditions, immediate derlying or Injury nits	a b d	AHLLE	Due to (or Due to (or to not resu	as a consequence as a c	Car uence of) uence of)	diove	ascula		23b. Did	tobacco use of Yes 2 No	3 Pro	Interval Between Onset end Death to the cause of death? bably 4 Vinknow Vere autopsy findings validable prior to ompletion of cause	
by Physician/Medical Examiner	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter University Chisease that initiated ever resulting in death Part II. Other eight	e (Final tion) conditions, immediate derlying or Injury nits	a b d	AHLLE	Due to (or Due to (or to not resu	as a consequence as a c	Car uence of) uence of)	diove	ascula		23b. Did	tobacco uee c Yee 2 No an autopsy med?	3 Pro	Interval Between Onset end Death to the cause of death? babbly 4 Dunknow Vere autopsy findings vailable prior to ompletion of cause if death?	
Completed by Physician/Medical Examiner	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initieted ever resulting in death Part II. Other eign	e (Final tion) conditions, immediate derlying or Injury nts nifficant condition	a b d	AHLLE	Due to (or Due to (or to not resu	as a consequence as a c	Car uence of) uence of)	diove	en in Part I.	10d. finside City Li 1	Interval Between Onset end Death to the cause of death? babbly 4 Dunknow Vere autopsy findings vailable prior to ompletion of cause if death?				
a properties of the properties	Immediate Caus disease or condi resulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death Part II. Other eign	e (Final tion) conditions, immediate deriying or Injury hts i) Last erred to medical	a b d	a on each line Ather D D G G D C C D C C C C C C C C C	Due to (or Due to (or to not resu	as a consequence as a c	Carruence of) uence of) uence of) uenca of)	dioVo	en in Part I.	Deeth (t	23b. Did 1 1 24a. Was perior	tobacco use of Yes 2 No	3 Pro	to the cause of death? babby 4 Unknow Vere autopsy findings valiable prior to completion of cause if death? Vere 2 No	
a properties of the properties	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ever resulting in death Part II. Other eight	e (Final tion) conditions, immediate derlying or injury his	a b c d ne contributing allah	g to death but	Due to (or Due to (or t not resu	as a consequence as a c	Carruence of) uence of) uence of) uenca of)	dioVo	en in Part I. 26. Place ot	Deeth (i	23b. Did 1 24a. Was perfu	tobacco use of Yes 2 No one)	24b. W e o o o o o o o o o o o o o o o o o o	to the cause of death? babby 4 Unknow Vere autopsy findings valiable prior to completion of cause if death? Vere 2 No	
a properties of the properties	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death Part II. Other eight 1. Other eight 25. Was case reaximing in the examinary of the exam	e (Final tion) conditions, immediate derlying or injury his	b d Hospital:	a on each line Ather D D G G G G G G G G G G G	Due to (or Due to (or t not resu	as a consequent as a consequen	Carruence of) uence of) uence of) uenca of)	dioVo	en in Part I. 26. Place ot	Deeth (i	23b. Did 1 24a. Was perfu	tobacco use of Yes 2 No one)	24b. W e o o o o o o o o o o o o o o o o o o	to the cause of death? babby 4 Unknow Vere autopsy findings valiable prior to completion of cause if death? Vere 2 No	
2 should be detected for the bunkletisher. pleted by Physician/Medical Examiner.	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ever resulting in death Part II. Other eign Cause (Cause Cause Ca	e (Final tion) e (Final tion) conditions, immediate derlying or injury his	b d Hospital: 28a pation not be larger in and to be larger in an and to be larger in an and to be larger in an analysis of the la	g to death but	Due to (or Due to (or to not result of 2 7 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as a consequence as a c	Car uence of) uence of) uenca of) nderlying	cause giv	en in Part I. 26. Place of er: 4 Nursing at yet	Death (ing Home	23b. Did 1 24a. Was period	tobacco use of Yes 2 No No none) Idenca 6 00 how injury occ	24b. We e o o o o o o o o o o o o o o o o o	to the cause of death? babably 4 Wunknow Vere autopsy findings valiable prior to ompletion of cause if death? Ves 2 No	
2 should be delected for use as the bunal-transit and properties as the bunal-transit and properties are pro	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ever resulting In death Part II. Other eight Sequential III. Other eight Sequential III. Other eight Sequential II. Other eight Sequential III. Other eight Sequential I	e (Final tion) conditions, immediate deriving or Injury nts nifficant condition Chronic erred to medical No eath 5 Pending investigs 6 Could no eath 1 Certifying	b d Hospital: gation not be 28e. gation pot be 28e.	and the state of the basis of t	Due to (or Due to (or to not result of the property of the pro	as a consequence as a c	uence of) uence of) uence of) uence of) uence of) M est, factor	cause give	en in Part I. 26. Place of er: 4 \(\text{Nursing yat k?} \) Yes 2 \(\text{No} \) No	Deeth (c)	23b. Did 1 24a. Was period to be cribe 1 Describe 1 Location 1 City or To	tobacco use of Yes 2 No one) idenca 6 Ohow injury occo (Street and Nur win, State)	3 Pro 24b. W 0 0 1 1 ther (Specurred	Interval Between Onset end Death Onset end Death to the cause of death? Obably 4 Unknow Vere autopsy findings vailable prior to ompletion of cause of death? Pres 2 No	
2 should be detected for use as the burial-transit pleted by Physician/Medical Examiner	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter un Cause (Disease that initiated ever resulting in death Part II. Other eight 1. Other	e (Final tion) conditions, immediate derlying or injury nts its its its its its its its	b d Hospital: Plation Physician: 1 Examiner: On and	g to death but I Inpatien Date of Injuny (Month, Day) Piaca of Injuny (Month, Day)	Due to (or Due to (or to not result of the property of the pro	as a consequence as a c	uence of) uence of) uence of) uence of) uence of) M et 3 D M occurrect restigation	cause give	en in Part I. 26. Place of er: 4 Nursing at yet yet one, date and pinlon, death of	Deeth (c)	23b. Did 1 24a. Was period to be cribe 1 Describe 1 Location 1 City or To	tobacco uee c Yee 2 No an autopsy med? It field Yes 2 No one) Idence 6 0 how injury occ (Street and Nur wm, State)	24b. We consider the constant of the constant	Interval Between Onset end Death Onset end Dea	
2 should be detected for the bunkletisher. pleted by Physician/Medical Examiner.	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that Initiated ever resulting In death Part II. Other eight Sequential III. Other eight Sequential III. Other eight Sequential II. Other eight Sequential III. Other eight Sequential I	e (Final tion) conditions, immediate derlying or injury nts its its its its its its its	b	and the second s	Due to (or Due to (or to not result of the property of the pro	as a consequence as a c	uence of) uence of) uence of) uence of) uence of) M et 3 D M occurrect restigation	cause given cause	en in Part I. 26. Place of er: 4 Nursing at k? Yes 2 No	Deeth (c)	23b. Did 1 24a. Was period to be cribe 1 Describe 1 Location 1 City or To	tobacco use of Yes 2 No No No Injury occ Street and Nur wn, State) Ceuse(s) and ridete end place 29d. Date sign	24b. We consider the constant of the constant	Interval Between Onset end Death Onset end Death onset end Death onset end Death obably 4 Unknow Vere autopsy findings vallable prior to ompletion of cause of death? Pres 2 No Note: No Death of Course of	
2 should be detected for use as the burial-transit pleted by Physician/Medical Examiner	Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter United Exercises that initiated ever resulting in death Part II. Other eight Part III. Other eight Part II. Other eight Part II. Other eight Part III. Other eig	e (Final tition) conditions, immediate derlying or injury tits) Last erred to medical No eath 5 Pending investig 6 Could not determine and fitte of certifier and fitte of certifier	b	g to death but I Inpatien Date of Injury (Month, Day) Piaca of Injury building, etc.	Due to (or	as a consequence as a c	uence of) uence of) uence of) uence of) uence of) uence of) M M eet, factor restigation	cause given cause	en in Part I. 26. Place of er: 4 Nursing at yet yet one, date and pinlon, death of	Deeth (c)	23b. Did 1 24a. Was period to be cribe 1 Describe 1 Location 1 City or To	tobacco uee c Yee 2 No an autopsy med? It field Yes 2 No one) Idence 6 0 how injury occ (Street and Nur wm, State)	24b. We consider the constant of the constant	Interval Between Onset end Death Onset end Death onset end Death onset end Death obably 4 Unknow Vere autopsy findings vallable prior to ompletion of cause of death? Pres 2 No Note: No Death of Course of	
pletely filled in by the funeral director, page 2 should be deteched for use as the burial-transit and pletely filled in by the funeral director, page 2 should be deteched for use as the burial-transit and an are also be entitled in the formula of the pletely provided in the provided	Immediate Caus disease or condiresulting in death service of the cause. Enter Un Cause. Enter Un Cause (Disease that initiated ever resulting in death service of the cause of	e (Final tition) conditions, immediate derlying or injury tits) Last erred to medical No eath 5 Pending investig 6 Could not determine and fitte of certifier and fitte of certifier	d	g to death but I Inpatien Date of Injury (Month, Day) Piaca of Injury building, etc.	Due to (or	as a consequence as a c	uence of) uence of) uence of) uence of) uence of) M eet, factor occurrecyestigation	cause given cause	en in Part I. 26. Place of er: 4 Nursing year k? Yes 2 No	Deeth (4) ng Home 286 286 286 ccurred	23b. Did 1 24a. Wasperfile Check only 5 Pescibe 1. Location (City or To	tobacco uee c Yee 2 No san autopsy omed? Yes 2 No one) idenca 6 O how injury occ Street and Nur wn, State) ceuse(s) and r dete end place 29d. Date sign JAN	24b. We consider the constant of the constant	Interval Between Onset end Death Onset end Death onset end Death onset end Death obably 4 Unknow Vere autopsy findings vallable prior to ompletion of cause of death? Pres 2 No Note: No Death of Course of	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Jan 200C /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner I OUSOA If Under 24 Hrs. 8 Hours Min. Limore If Under 1 Yeer 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys 108M 2□ F Maryland Yrs Director Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inaide City Limits ed other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 7No Md Directo 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 9832 1SA 21234 Rol permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental hygiene. Important: If item 27 is marked other any injury or other the state of the sta Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Yeer or Detes: Wes Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) Rece - American indien, Bleck, White, atc. 11. Meritet Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify by Specify: White 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Shiphulding + Elementery/Secondary (0-12) Coitege (1-4or 5+) walehouse 18. Mother's Name (First, Middle, Meiden Surgent) 17. Fether's Neme (First, Middle, Last) Be 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Md ltimore ema_ SOOUSE 20c. Location - City or Town, Stete Dete 20a. Method of Disposition lan 17 1 Burlei 2 □ Cremetion 3 □ Removei from State Valley 4 ☐ Donetion 5 ☐ Other (Specify) Hem Gars 2000 22. Name and Address of Facility EVans 21. Signeture of Fuperel Service Licensee Funeral Do not enter the mode of dying, suchles cardiec or respiratory Md 21254 Fert1. Enter the disease, or complications that caused the deeth, shock, or heart failure. List only one cause on each line. Approximeta interval Betw Onset and D **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examine Examine or Attending Physician: The law requires that the deeth certificate be executed Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medical Due to (or es a consequence of) Pert ft. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24e. Was en autopsy performed? 24b. Wera eutopsy findings available prior to completion of cause of daath? Completed peen hes After this certificate 1 Tes 200 No 25. Wes case referred to medicat examiner? director Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation To the Hospital or Attendif within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29e. Cartifler Certifying Physicfan: To the bast of my knowledge, deeth occurred at the time, data and piece, and due to the cause(s) and menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title of certific 29c. License number 29d. Dete signed (Month, Day, Year) 2000 30. Name end address of person who complated gause of death (Item 23a) (Type, Print) N. Charles St. Towson, Md. 21204 31. Date filed (Month, Dey, Char) 32. Registrer's Signeture State JAN 1 9 2000 Registrar



DHMH 16 Rev 6/95

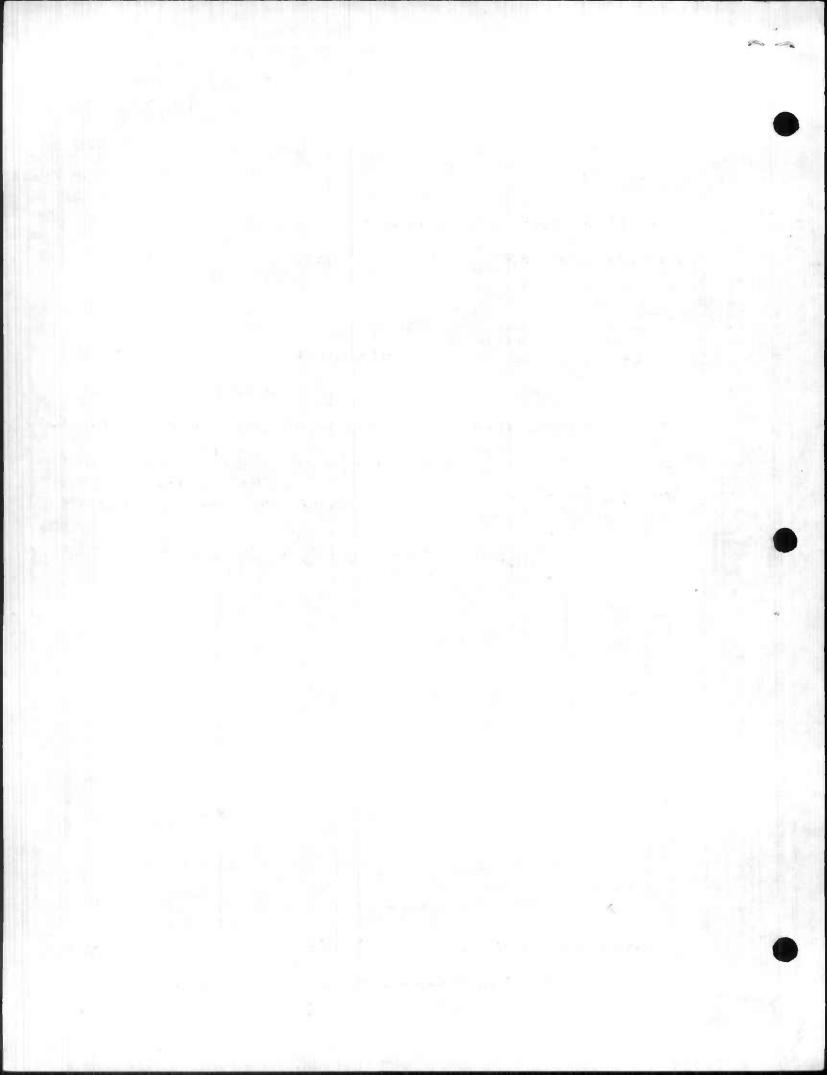
State

Registrar

31. Date filed (Month, Day, Year) JAN 19

oaks

32. Registrar's Signeture



DHMH 16 Rev 6/95

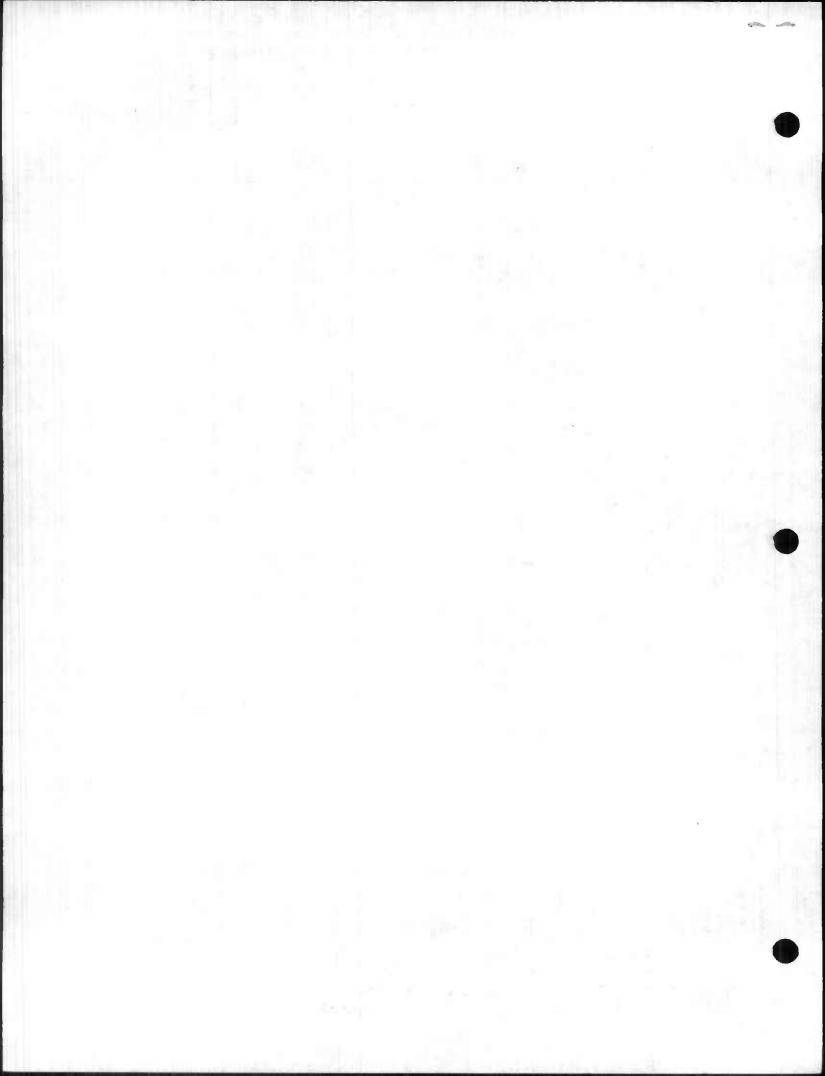
State Registrar 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

Registrar's Signatura

31. Data filed (Month, Pay Year)

January 18, 2000

M) 21208 Jehrah I.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Allan Van Lee Sheffer January 2000 16 5:05pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1206 Bramblewood Court Condo Unit 104 Belcamo 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1☑ M 2□ F Months Days Hours 71 216-24-7701 Baltimore, Maryland Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Bramblewood Ct. Condo Unit 104 21017 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Merital Status Bleck, White, etc. 1 ⊠ Yes 2 □ No Navy If Yes, Give Year or Dates: 1 ☐ Never Married 2 N Married 1 Yes 2K No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Jos. A. Bank Clothier Mechanic-Sewing Machine 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Sheffer Margaret Stein 19a. Informant's Name/Reletionship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Mary Sheffer 1206 Bramblewood Ct. Condo Unit 104, Belcamp, Md. 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Dete 1 N Burial 2 Cremetion 3 □ Removel from State 1/20/2000 Baltimore, Maryland Stanislaus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 21. Signature of Funeral Service Licenses 262 S. Conkling Street, Baltimore, Maryland 21224 Henry eplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a Part 1. Enter the disease or or shock, or heart failure. Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 2 ☐ Accident

Physician/Medical Examiner attending physician and lor use as the burief-transit The law requires that the death certificate be assecuted Box 68760. signed by the a P.O. Records. Completed page 2 s of Vital or Attending Physician: Be To this funeral edical Certification: Affer Division death. tha f within 24 hours after deat To the Funeral Director: lilled in by

þ

Physician

/Medical

Examiner

Funeral

Director

r 28a-f ahow

"natural", or items 23s or

Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental hygiene.
ant: if itam 27 Is marked other than 'natural', or fler ury or other transmitter or mental transmitter or with the file of the transmitter or other or other transmitter or other or

Department of Important: If it any Injury or o

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

with the Maryland

death

25. Was case referred to medical axaminer? 1 Yes 2 No

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Jan 18th 2000

HANKLIN SPVARE HOSPITAL BALTIMORE HOSPITAL BALTIMORE MADHU CHAUDITRY

State Registrar

completely

31. Dete filed (Month, Day, Year)

JAMY 1 9 ZUUU

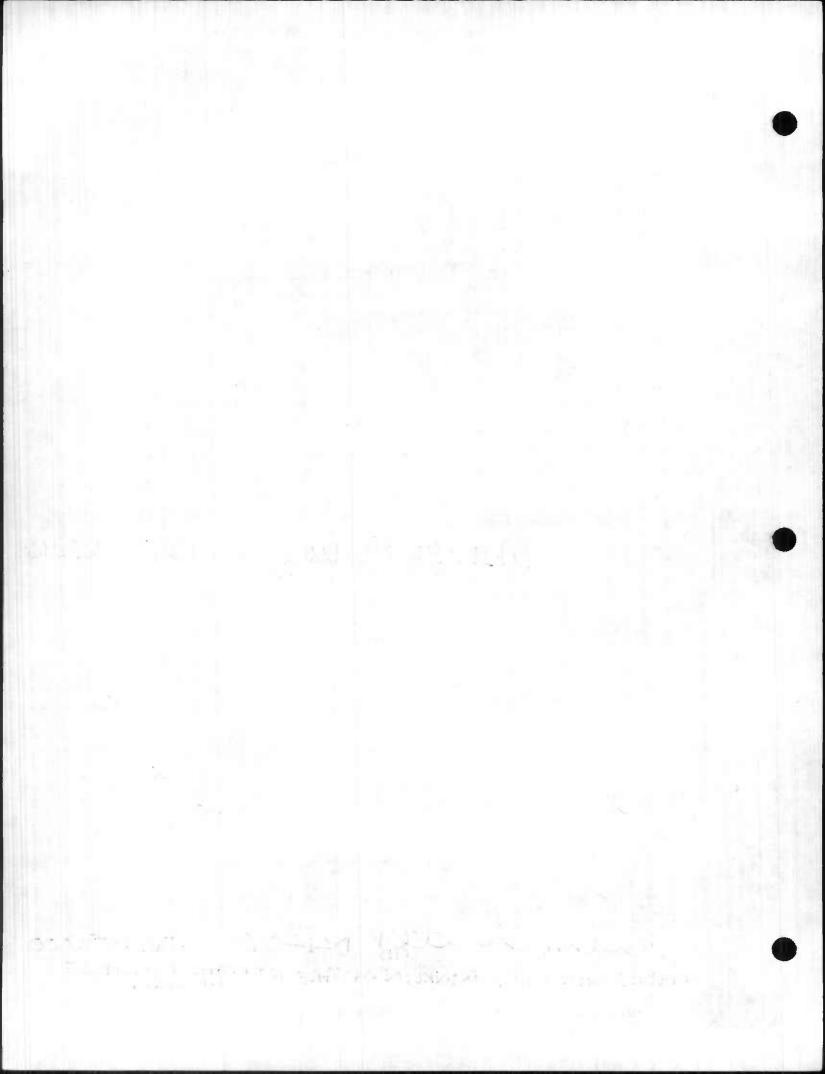
6 ☐ Could not be

2 Medical Examiner: On the basis of examiner and manner stated.

32. Registrar's Signature

Sparks

To the Hospital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evelyn Antoinette Stack 5:33 PM January 16, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric & Rehab Center Essex If Under 24 Hrs Baltimore If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months Days

Essex

21221

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

Homemaker

1 Yes XX No Specify:

16a. Decedent'a Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired)

10c. City, Town or Location

March 15,1912 Maryland

10g Citizen of What Country?

Specify

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

Own Home

United States

14. Race - American Indian, Bleck, White, etc.

White

10d. Inside City Limits

1 Yes 2000

2/2/1

1□ M 21 F

Baltimore

12. Was Decedent Ever in U,S. Armed Forces?

1 Yea 2 No
If Yes, Give
Year or Dates:

College (1-4or 5+)

Funeral Director

217-26-8148 Usual Residence of Decedent

10b. County

603 Riverside Drive

1 Never Merried 2 Married

3 □ Widowed 4 □ Divorced

10s. State

Directo

Funeral

þ

Maryland

10e. Street and Number

the Maryland show ms 23a or 28a-f i r than "natural", or hama 23a or the Medical Examiner must be Hyglene.

filed within 72 hours after permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any fillury or other traumatic event gade.

altimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the buriel-transit Box 68760. 99 signed by the a d be detached i P.O. Records. The lew requires should l page 2 Division of Vital this funeral After death.

or Attending Physician: after death Director: 5 filled in 24 hours To the Hosp within 24 hoi To the Fune completely fi

Examiner Physician/Medical à Completed Be Certification: To

Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years 17. Father's Name (First, Middle, Last) Be Benjamin Rhodes Immediate Cause (Finel disease or condition resulting in death)

(Not Known) Anna 19a. tnformant's Name/Relationship (Type, Print) (Son) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin H. Stachowski 603 Riverside Drive Essex, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 1/19/2000 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 0. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line. Approximate Intervat Between Onset and Death ever Due to (of es e consequence of): n Mual asala Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hyzethy vicus Jomet Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Vonknown branne 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 20 No 25. Was case referred to medical examiner?

1. Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mi D31464 1118/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 221 N. Eulaw It fonte 308, 13alt mis

DHMH 16 Rev 6/95

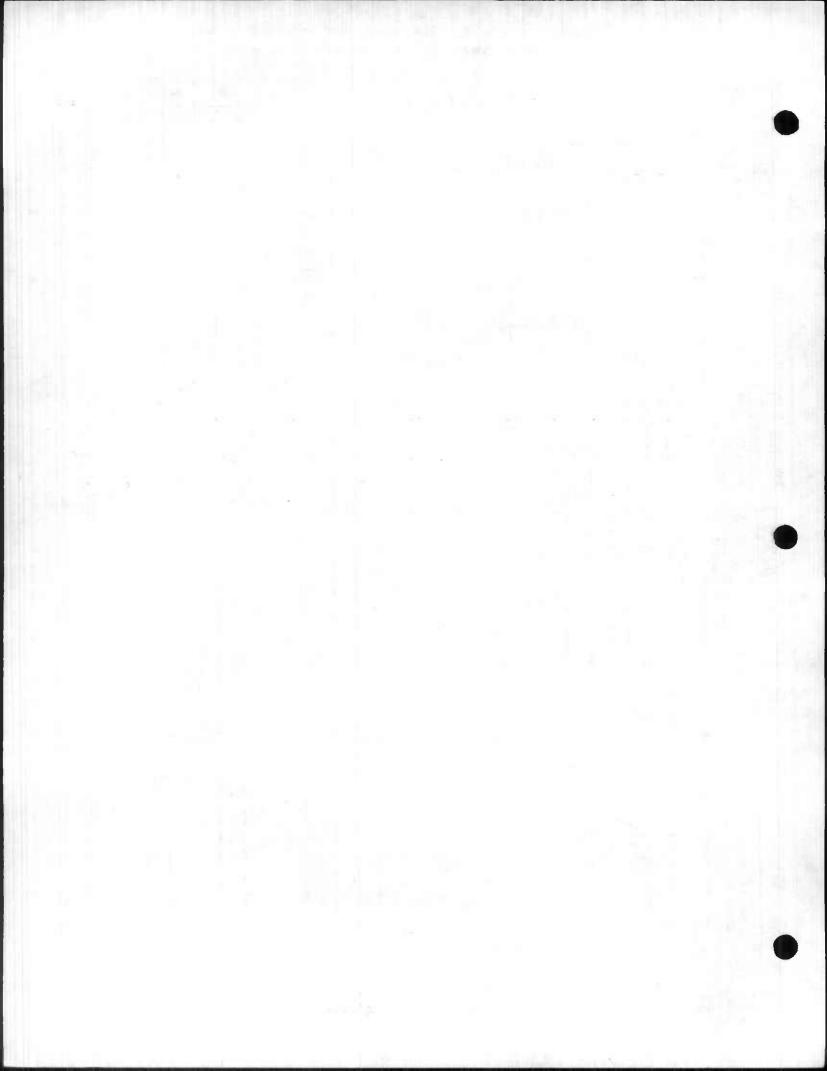
State

Registrar

ooils

HAS HMI

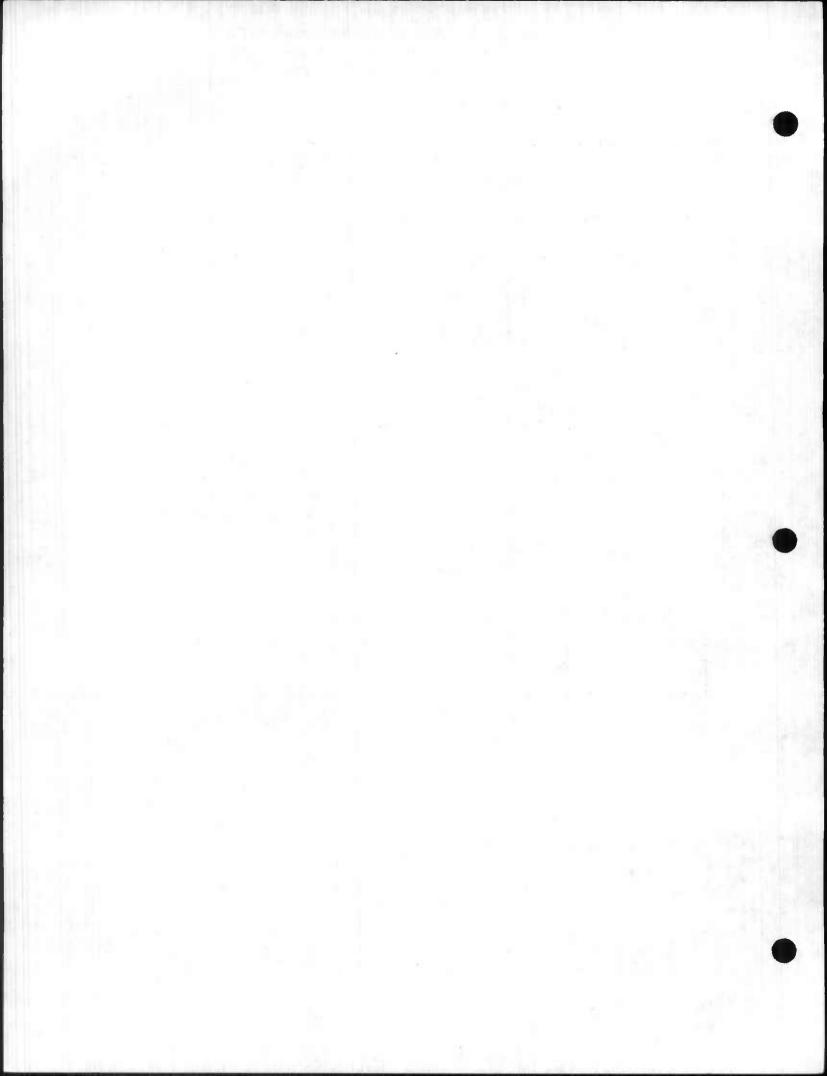
32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

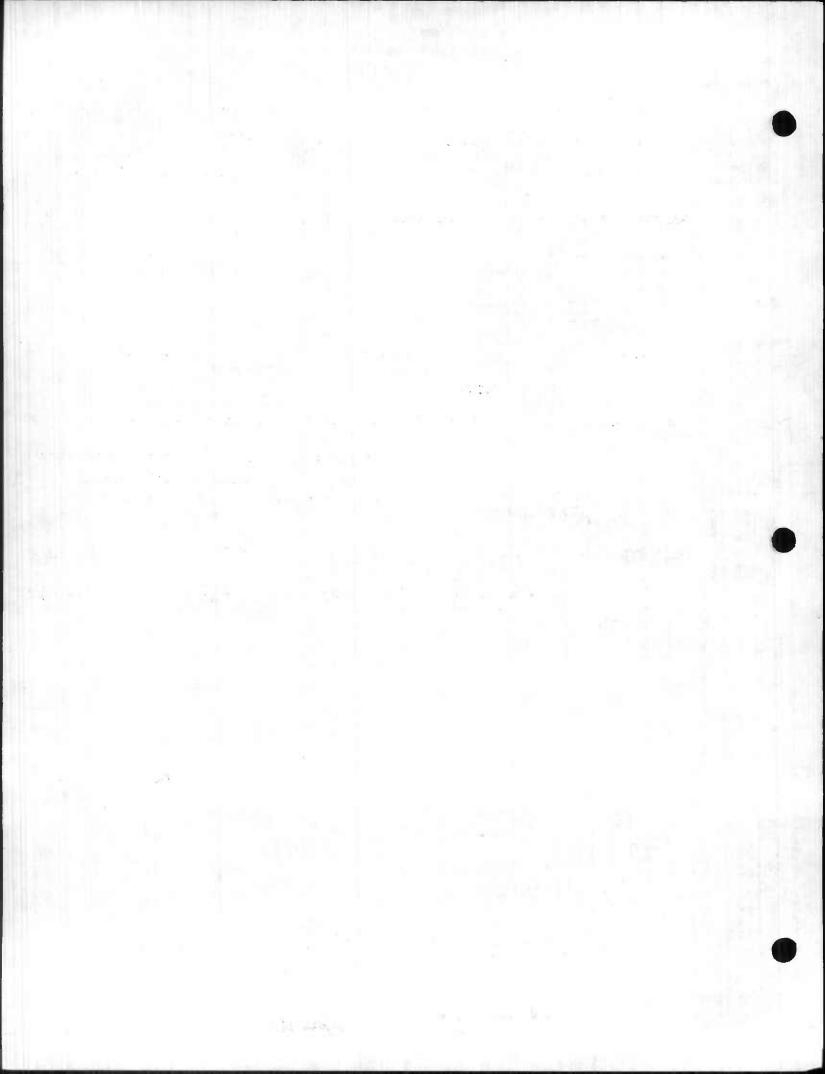
State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	R	eg. No.				
Physician /Medical	Decedent's Neme (First, Middle,		D. Schra	der		2. Dete of Dee Month January	Dey Yea				
Examiner	4a Fecility Name (If not institution, Genesis Elder				4b. City, Town, or L Baltimor		4c. County of De				
Funeral Director	217 26 3065	i. Sex 7. Ag 1 ☐ M 2 🖾 F	94 Yrs	Months Davs		8 Date of Birth (Month, Day April I	9,1905	sirthplace (State or Foreign Country) Pennsylvania			
Maryland 4 show fied at	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel	10c. City, Town o		7 10			10d. Inside City Limits 1 Yes 28 No			
ith with the Marylan 23s or 28s-f show ust be notified at		e Road		10f. Zip Code 212:	25	1	0g. Citizen of What (Country?			
Name Name Dec. m	11. Meritat Status 1 Never Merried 2 Married	12. Wes Decedent Armed Forces?		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🖾 No		pecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify:	nerican Indian, hite, etc. White			
Z I Z 1 D-UUZU ed within 72 hours all sypiene, er than "natural", or et the Medical Exam Completed by F		Education grade completed) Cottege (1-4or	5+)	ecedent's Usuel Occu Give kind of work done de. DO NOT use retin hild care	during most of work ed)		16b. Kind of Busines Day car				
Maryland and 2 should be filed the and Mental Hyg. 77 is marked other treumatic event, To Be C.	17. Father's Name (First, Middle, La		iner			ne (First, Middle, 1 essie Sal	Maiden Sumeme) nds				
	19e. Informent's Neme/Reletionship Ralph Schrader		302	Aeiling Address (Street 29 Leib Ro		kton, Ma	ryland 21	120			
Page 1	20a. Method of Disposition 1 2 Burial 2 Cremetion 3 4 Donetion 5 Other (Spa	cify)	cametery,	isposition (Name of cremetory or other place) ore Nation	al	Dete 1/18/00	Baltimore	e, Maryland			
Desmit. Departmine posts any injury i	21. Signeture of Eunerel Service Li	Snamu	ourles-	22. Name end Addr 4001 Ritcl			uneral Hor imore, Md				
Physician /Medical Examiner per	Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	ARTE	Due to (or as a con	COVOT (nsequenca of):	e can	D (2)	AS CUCAN	1046			
ocertificate be noting physicia use as the burn	Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of):										
oy the ached	Part II. Other significant condition	s contributing to death b	iven in Pert I.		ld tobacco uss contributs to the causs of death? Yes 2□No 3□Probably 4□Unknow						
The law requires that the law requires that page 2 should be detected by P		3.4	24a. Wes a perfor	24a. Wes an autopsy performed? 24b. Ware autopsy find available prior to completion of cau of death?							
= F # & O			-0 Pt		1 Yes 2 No 1 Yes 2 No						
	25. Was case referred to medical exeminer?	Hospitei:	ent 2 ER/Outp	atient 3 DOA	ther:	th (Check only or		oncity)			
After fune	27. Manner of Death 1 Netural 5 Pending 2 Accident investige	28a. Dete of Inju (Month, De	ury et ork? Yes 2 No	tome 5 Residenca 8 Other (Specify) 28d. Describe how injury occurred							
DIVISION Control of the Hospital or Attending Pathin 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no determin	building, et	City or Tow	n, Stete)	Rural Route Number,						
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete and placa, and due to the cause(s) end manner stated.										
b type of the second se	29b. Signeture and title of certifier	PANUALY									
5			death (Item 23a) (Ty	ype, Print) S - HAA	OUER S	57. BA	RTIMOR	e 21225			
StateRegistrar	31. Date filed (Month, Day, Year)	9 2000 32. Registr	ray's Signature	& Sp	als						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Sunstrom **Physician** athryn 9:25 Pm marion 2000 January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth HOSPICAL imore N/A Ball Marbor (enler If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months 1□M 2X F Hours 213 14 9652 Yrs 80 Director 27, 1919 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Fifth Avenue 21225 U.S. deeth Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Marital Status 12. Wes Decedent Ever in U.S. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours effer and of Health and Merial Hygiens.
Htt: If feen 27 le marked other than "natural; or fea any or other traumatic event, the feature in any or other traumatic event, the feature is a second event in a feature in a second event eve 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2⊠ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17 Father's Neme /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Lillian Betz Edward Lockett 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21225 James Sunstrom Sr. / Husband 208 Fifth Avenue 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If eny injury or page. 1/21/00 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 pomeroush 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Keto acidosis disease or condition resulting in death) Examiner myo Cardial infarction Examiner physicien and the buriel-transit The lew requires that the death certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown been signed by should be detact 1 Yes 2 No à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 a 2 No 1 Yes 1 Yas 2 No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical eleily filled in by the funeral director; 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 40 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Nopetient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. Ljepnse number 29d. Date signed (Month, Day, Year) 12291 Salama January 17.2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salama, 3001 South Hanover Street, Ballimore, MD 21225 32. Registrar's Signithum 2000 State 9 Registrar DHMH 16 Rev 6/95

ORIGINAL



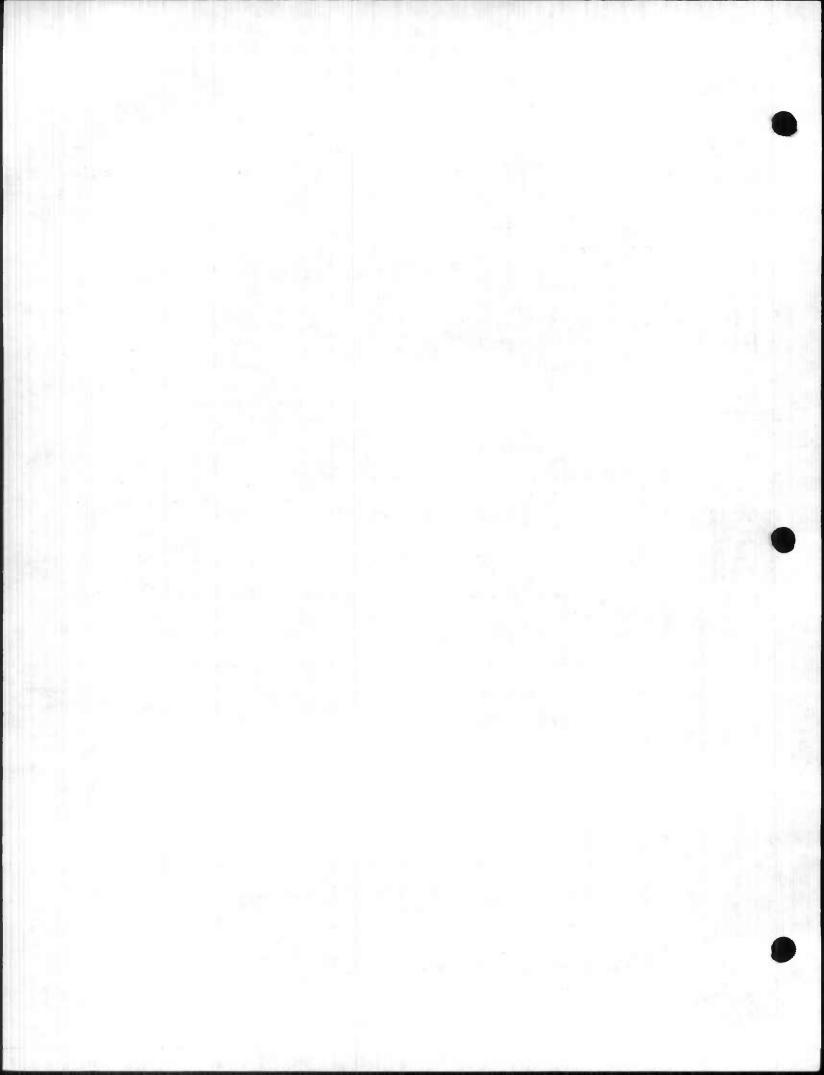
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1400 Clara Marie Solloway 4b. City, Town, or Location of Death 2000 /Medical 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Linder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 280 F 220 09 3654 86 Feb. 19, 1913 Director Maryland Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rait, or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Edgewood 10e Street and Number 10f Zin Code 10g, Citizen of What Country? 2414 Sycamore Lane 21040 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 natural', or 1 ☐ Yes 2 No Specify: Specify: à 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Payroll Clerk 12th Ft. Meade - Civilian permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygh
Important: If Itam 27 is marked and language. Saltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be (Not Available) Philip Potter Clara 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Solloway 2414 Sycamore Lane Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Glen Haven Memorial Park 1/20/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture-of Funeral Service Licensee Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramusous Do not enter the mode of dying, such as cardiac or respiratory arrest, ons thet caused the deeth. 23a. Part1. Enter the diseese, or complice shock, or heart feilure. List only on Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SPIRATOR ag. Examiner Due to (or as a consequ Examiner acerba Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Box 68760. Physician/Medical Due to (or as a consequence ong Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobaccques contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 20 No 1 Yes 2 No Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To shis 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Division 1- Naturai 5 Pending 1 Tyes 2 No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier \$ 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2100 31. Date filed (Month, Day, Year) M. VA 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

olloway.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MARTHA SLAWINSKI 5:30 PM JAMARY 00 17 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death MERCY MEDICAL BALTWORE CENTER Hours Min. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5. Social Security Number 9. Birthplaca (Stata or Foreign 1 M 2 KF Days 79 060-14-2952 Yrs. USA Usual Residence of Decedant 10a Stata 10h Count 10c. City, Town or Location 10d. Insida City Limits Md. 1 Yas 2 No Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 524 South Curley St. 21224 USA 12. Was Decedanf Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 XNo Specify: White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16e Decadent's Lisual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantery/Secondary (0-12) Collaga (1-4or 5+) Home Maker Own Hame 12 18. Mothar's Nama (First, Middle, Maldan Surnama) 17. Fathar's Nama (First, Middla, Last) Rosalia Kwiatkowska Uladyslau Olszewski 19b. Meiling Addrass (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) John Slawinski-Son 18 Meadow Run Court, Sparks, Md. 21152 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cemetery 1/20/2000 Dundalk, Md. 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home Inc. 21. Signature of Funerel Service Licensea Sary R. Distovanni Cary R. Disgovanni Car Parts False the disease or complications that can 5305 Harford Rd. Baltimore, Md. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onsat and Death PULMONARY EDEMA Immediata Causa (Final disaasa or condition rasulting in daath) WEEK Dua to (or as a consequanca of) CARD 10 MY o PATHY Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disaasa or Injury that Initiated evants resulting in death) Last ACUTE MYELOGENOUS LEUKEMIA Dua to (or as a consequence of): MY ELODYSPLASTIC STNOROME Part II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown SYSTEMIC LUPUS BRY PHEMATOSIS 24b. Wara autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy performed? DEEP VENOUS THROMROSIS

attending physician and for use as the buriel-transit 88 Division of Vital Records, P.O.

Physician/Medical þ Completed

Examiner

or Attend efter death Director: To the Hospital o within 24 hours of To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

g

Completed

Funeral

Director

the Maryler

ir than "naturel", or items 23s or 28s-f show

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "nature!", or its

permit. Peges 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other treum pace.

Physician

/Medicai

Examiner

Saltimore, Maryland 21215-0020

Be 0 Certification: edical

10

						1 Tas	2□No	1 Tas	2)K No		
25. Was casa rafarrad to medical					26. Placa of D	aath (Chack only one)					
axaminar? 1 ☐ Yas 2	No	Hospifal: 1 Inpatiant 2	ER/Outpatienf	3□ DOA	Othar: 4 Nursing	Homa 5 Rasidano	one) danca 6 □Othar (Specify) now Injury occurred Straat and Number or Rural Routa Non, State)				
27. Mannar of Deat 1 Natural 2 Accidant	h 5 🗌 Panding Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c.	Injury at Work? 1 ☐ Yas 2 ☐ No						
3 ☐ Sulcida 4 ☐ Homicide	6 Could not be determined	28a. Place of Injury - Af h building, etc. (Special	oma, farm, straai	t, factory, of	fica	28f. Location (Straat and Number or Rural Routa Number City or Town, Stata)					
29a. Cartiflar (Check only one)	Certifying Phy 2 Medical Exam	yercian: To the best of my known iner: On the basis of axemina end mennar stated.	owledga, death o	ccurred at ti	ha tima, data and plac my opinion, death occ	ce, end dua to tha caus curred at the time, date	a(s) end men end piece, er	ner as stated. nd due to tha ce	use(s)		

29d. Data signad (Month, Day, Year)

29b. Signature and title of certifie 29c. Licansa number PESIDENT 1/17/00 P10290

PHYSICIAN 30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

S. GREEN ST. BATTMORE, MD

31. Data filed (Month, Day, Year) Registrar

32. Ragistratis Signatura JAN 19 2000



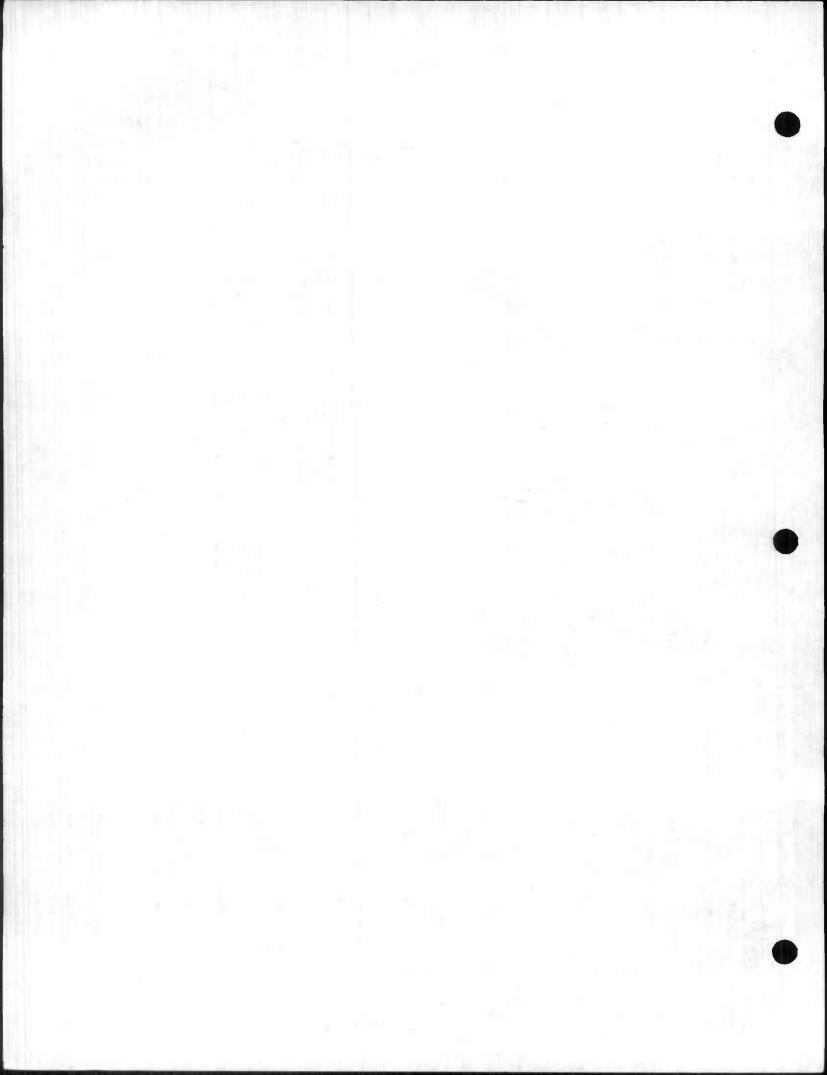
the common to the second of th DE VERON CHARLES THE the state of the s Artigist unit year year BALLERY & BALLERY CORP. The state of the same of the same

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

9	00	01	11	
		~	4 114	6

							Ce	rtificat	e of	Death			Reg	. No.		011110		
			e (First, Middle, I									2. Dete of Month		Day	Year	3. Time of Deeth		
sician edical	Ge	enevie	ve Virg	inia	Snow							Janu	ary	^D ₁ , 2	000	10:10 A		
	4a Facili	lity Name (If	f not institution, g	give stree	t and numb	per)				4b. City, To	wn, or Lo	ocation of De	ath	4c. County	of Death			
			re Nurs								seda				ltim			
5.		1 Security No		S. Sex 1 ☐ M		Age (In yrs. 89		Months Months		If Under Hours	Min.	8. Dale of (Month,	Birth Day, Yo	, 1910	9. Birthp	elece (State or Forei try) ryland		
U		16-03- Residence of				03						nagas	0 2	, 1510	110	Tyrana		
1	10a. Stet	ate	10b. County			10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Limi		
ig N	Mary	yland	Balt	imore	e		Esse	ΣX								1 ☐ Yes 2 💢 N		
X	10a. Street and Number 10f. Zip Code										10g	. Citizen of W	/hat Cour	ntry?				
- C	152	26 Den	ton Roa	d					21:	221				Unite	d St	ates		
Funeral		itel Stetus	TOOK NOU	12. W	Ves Deced	ent Ever in U	S. 13.	Wes Dece			igin? (Sp	ecify Yes or Rican, etc.)	No-		- Americ	ean Indian,		
by Fu			ed 2 Married	d 1	Yes 2	K) No				Specify:		Thours, oto.,		Specify		hite		
	3)(1)		4 Divorced		eer or Det	0\$:							1.5					
9		(Speci	15. Decedent's ify only highest of	Education grade con	n n <i>pleted)</i>		(Give	dent's Usu kind of wo DO NOT u	rk done	during mos	t of work	ing	16	b. Kind of Bu	isiness/Inc	dustry		
Completed	Eleme	Elementery/Secondary (0-12) College (1-4or 5+)												Own	Home			
	17. Fath	10 ner's Neme /	First, Middle, La	ist)				Homemaker 18. Mother's Name					die. Me	-	Oille			
m				,											-,			
٩		ohn F.	MUCK me/Reletionship	n /Time E	Print l		10h Maili	ina Addres	c /Strant			et Ba		ity or Town,	State Zin	Code)		
			zer / S					16 Gr						e, MD				
2		thod of Disp		1216		20b. P	Plece of Disp	osition (Ne	me of		iluc	Dete	_	c. Location -				
	1)(Burial 2	Cremetion 3 5 Other (Spec		vel from St	ete ete	kwood	Ceme	tery			8/2000						
2	21. Sign	nature of Fur	neral Service Lic	HA			L	2. Name er _eona1	rd J	. Ruc	k, I	nc. Fu	ner	eral Home ore, MD 21214				
2	23a. Pa	art1. Enter Ih	ne disease, or co	omplication	ns that ceu	sed the deat									2121	Approximate Intervel Between		
	sno	lock, or neer	n railure. List on	ny one ca				Do not enter the mode of dying, such es cardiac or respiratory							Onset			
T I	Immediate Ceuse (Finel disease or condition resulting in death) e. Melastatic Lu									unc	3) (Cancer un-know						
1	resulting	g in deeth)		Θ	,	Due to (o	or as e conse	quenca of)		- 6	7-				1			
ne.				Due to (or as e consequence of):														
Examiner	Sequent	itially list cor	nditions.	b. —		Due to (o	r es e conse	e consequenca of):										
E	if any, le cause.	ntially list con eeding to im Enter Under (Disease or I	mediete												1			
OI	filed willie	(Disease or I leted events g in death) L		C		Due to (o	r as a consec	quence of):			-							
3				- 4														
20				- 0														
Sic		_	cant conditions						ceuse gi	ven in Part	1.	23b. D	id tobs	cco use cor	ntribute t	o the cause of deat		
Ē	I	ocho	mic ,	Con	ndia	my	pall	y,				1	☐ Yea	2□ No	3 Pro	bebly 4 Unknown		
d by		417 0	1	Λ Λ		1016						24- 14	lac a=	autopsy	24h W	ere autopsy finding		
Completed by Physician/		171 1	٧,	11/	94 m	WMT	in						erforme		av	eilable prior to		
du															of	death?		
ပိ												1	☐ Yes	2 No	1[Yas 20 No		
m	9X8/7	miner?	red to medical	Hospit	tel·				Ott			h (Check on						
6	1 🗆 \	Yes 201			1 🗆 Int		ER/Outpatie		UA	480 14	ursing Ho			inium occur		(y)		
6 6	1-01	Netural	5 Pending		(Month,	Day Year)	Injury	м	28c. Inju Wo	rk? Yes 2	l No	28d. Describe how injury occurred						
Cat		Accident Suicide	investiget	t be	la Place o	f Injury At he	ama form of			162 2	140	28f Locatio	200 Leasting (Chart and Mumber on Burel Boute Mumber					
Certification:		Homicide	determine	ed 20	28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Locati							City or	cation (Street end Number or Rural Route Number, ty or Town, Stete)					
Ö 2	29a. Cer	ertifier	1 Certifying F	Physician	: To the b	est of my kno	wledge, deet	th occurred	et the ti	me, date e	nd plece.	and due to t	he caus	se(s) and ma	nner as s	stated.		
edical			2 Medical Ex	taminer: (is of examine												
	29b. Sign	neture end	title of certifier	112						se number				. Dale signe				
		A	_ العار	M-D					D-	.38	75	4	0	1-17	- 20	000		
2	30 Nem	r W	ass of naroon wh	no comple	ted cause	of death (ites	n 23e) (Tymo	Print)				,						
3	AAA	ALIKA				H D	4 - B	AST	BRI	V S.	SLVD	, M	D.	_ 21	22	-1 .		
3	7.11	, ,																
	MA 31. Date	ALIKA	h, Day, Year)		M.	of deeth (Item HO) gistrer's Signa		Print) AST	DER	2	- 38 2N P.	1-38 15 2N BLVD	1-38 154 2N BLVD, M	2N BLVD, MD		2N BLVD, MD-2122		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 19a per infor. G783 5/2/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** ORRESTER

4a Facility Name (If not Institution, give street and number) 6.02 01 09 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Hospital Baltimore n/a 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. A. Dute of Birth (Month, Dey, Year)

79 Yrs. Months Days Hours Min. (Month, Dey, Year)

May 1, 1920 5. Social Security Number Birthplace (State or Foreign Country) **Funeral X**M 2□ F 218-03-7794 NC Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Haalth and Mental Hyslena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified as once. Md. n/a Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2112 N. Smallwood Street 21216 USA Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 MXss 2 □ No If Yes, Give Year or Dates: t4. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2KD Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) ementery/Secondery (0-12) 9th Grade Coppin State College Maintenance Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lemon Shaw Rebecca Barnes 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3905 Wabash Avenue Apt. 1B Baltimore, Md. 21215 19a. Informant's Name/Relationship (Type, Print) daughter Glinda S. Gathers 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State King Memorial Park Jan.15 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21 Signature of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 ۶. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical ACUTE MYOGARDIAL INFARCTION. Examiner Due to (or as a consequence of): Examiner PNEUMONIA; ARDS CENKADAM physician and the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last SEPSIS Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending pl signed by the at d be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? post-anstructiony symdromE, y spistro-1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopey findings available prior to completion of cause of death? Completed 24a. Was an autopsy JEJUNA REFLUX. certificata has t irector, page 2 s 110 100 2 No 2 No Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was cese referred to medicel examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 1 Impatient 2 □ ER/Outpatient 3 □ DOA Certification: To this funaral 27. Menger of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Neturei 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat in by tha 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01/09/2000 124025 40 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) LAYILL-MD. 7601 OSLER Drive, BALT. MD 21204

Registrar

State

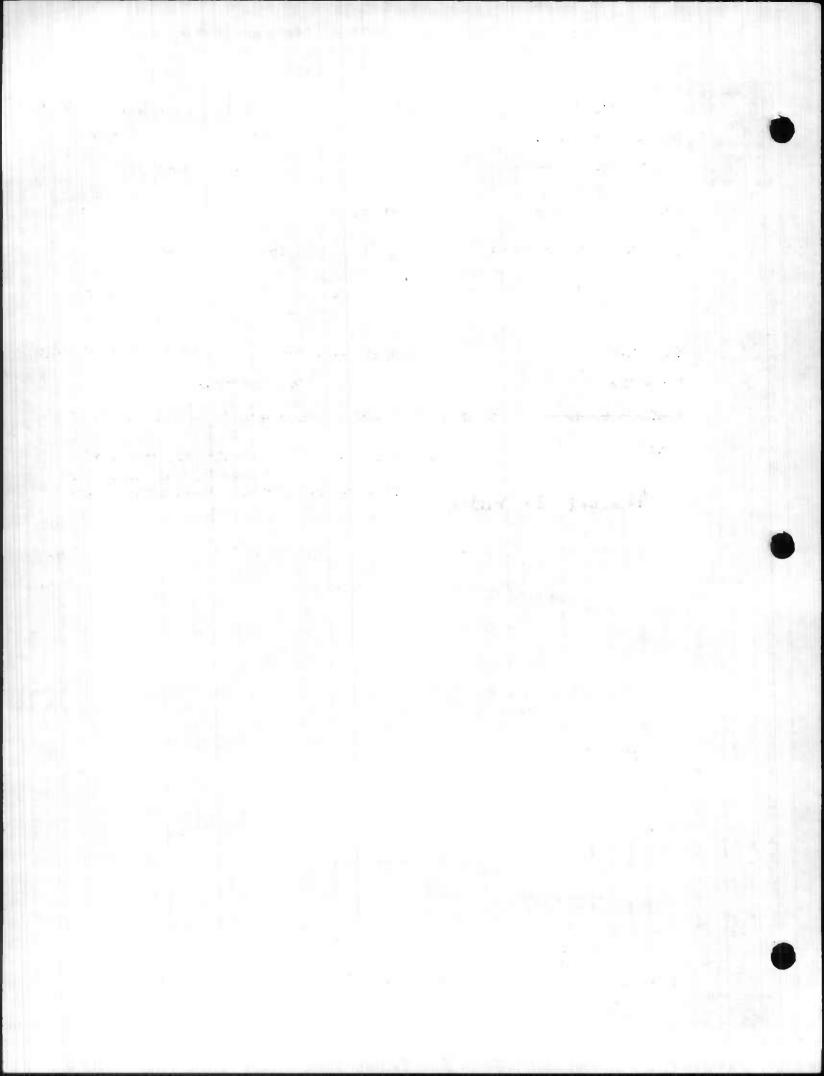
EDUARDO

31. Date filed (Month, Day, Year) JAN 1 9 2000

.0

32. Registrar's Signature

books

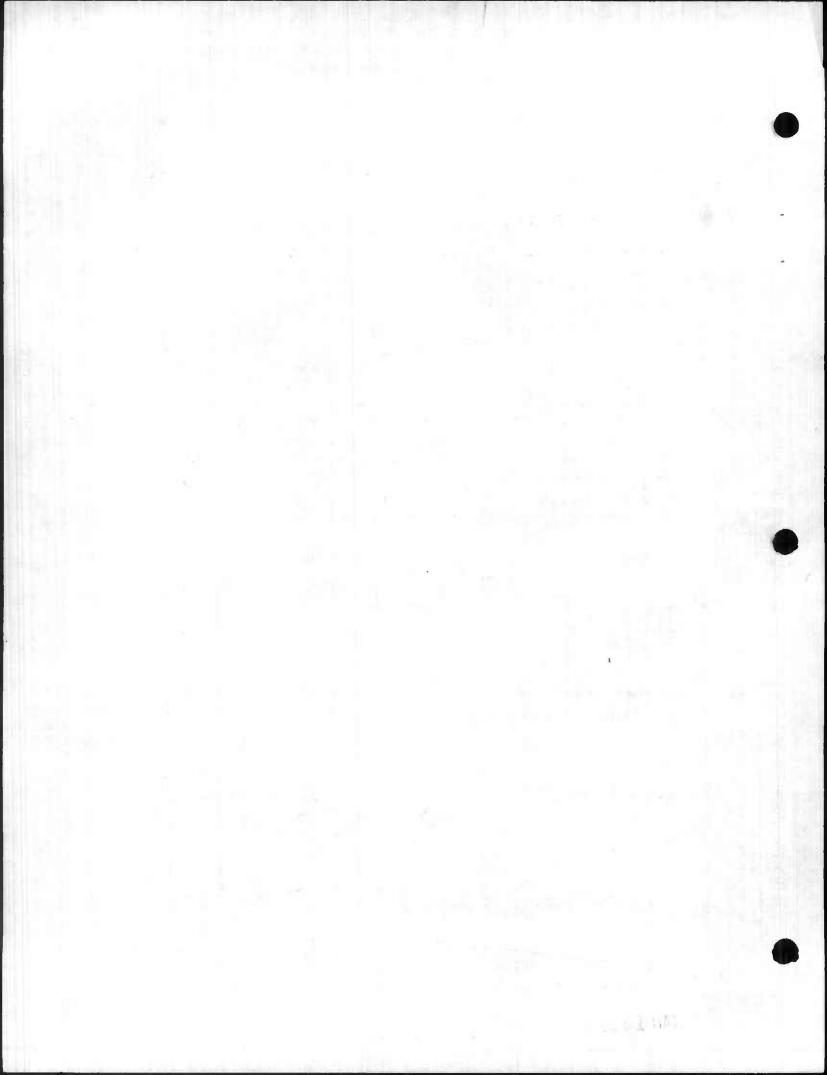


Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo

	Decedent's Name /First Middle La	Certificate of Death Decedent's Name (First, Middle, Last)				Reg. No. 2. Date of Death 3. Time of D			. Time of Death
hysician	RETA	•		SILVERMAN		Month JANUARY	Day Year	Year	1:45 PM
/Medical Examiner	4a Facility Name (If not institution, given GENESIS HOMEWOO)				4b. City, Town, or L BALTIMORE	ocation of Death	4c. County o	f Death	N/A
uneral rector	5. Social Security Number 6. S 212–12–4256	ex 7. Age	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1) FEB 20		9. Birthplace Country)	(State or Foreign
show of all	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d.	Inside City Limits
ctor cto	MD BALTIM	ORE	BALTIMORE	3					1 ☐ Yas 2 No
thems 23s or 25s-f sho instrinuist be notified at funeral Director	10e. Street and Number 1812 RAMBLING R	IDGE LANE	#102	10f. Zip Code	21209	10	g. Citizen of Wr U.S.A		
by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ver in U,S. 13. 1	Vas Decedent of I Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American I , White, etc.	ndien, WHITE
t, the Medical I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give		pation of during most of work ad)	ring	6b. Kind of Bus		
c event, o Be C	17. Father's Nama (First, Middle, Last) SAMUEL		HORWITZ	- Table 1	18. Mother's Nam	e (First, Middle, Ma		TOPAZ	
traumat	19a. Informant's Name/Relationship (19a PAULA SICKER /				and Number or Rui				
y or other	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State	20b. Place of Dispo	sition (Name of natory or other pla	SFARD		Oc. Location - C		State
any injur	21. Signature of Plineral Service Licen		OHR KNESS	Name and Addr		SOL LEV			
Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as a consequence to (or a)	Heart uence on:	Failure	-Dias	tolic	iy.	vulej ears
etached for use. Physician/M	Parl II. Other significant conditions or		t not resulting in the u	nderlying cause g	iven in Part I.	23b. Dld tob	~	ribute to the	e cause of death?
b b	Amal h	bullaton)			24a. Was an	autopsy	24b. Wera	autopsy findings
Completed						pertorm		of dea	
	25. Was case referred to medical				00 Div. (D.	1 Yes		1 U Ye	as 2 No
	examiner?	Hospital:	nt 2 ER/Outpatien	t 3 DOA OI	ther	th (Check only one one 5 Residen	_	(Specify)	
9 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Tima of	28c. Inju		28d. Describe how			
ral Director: After tilled in by the funeral Certification:	3 Suicide 6 Could not be determined	ry - At home, farm, str (Specify)				28f. Location (Street and Number or Rural Routa Number, City or Town, State)			
completely filled Medical Ce	(Check only 2 Medical Exart one)	ysician: To the best of siner: On the basis of a and manner state	examination and/or inv	estigation, in my	opinion, death occur	red at the tima, dat	te and place, ar	nd dua to the	cause(s)
2 8 8 8	296, Signature and this of certifier		Astrodino	29c. Licen	se number	29	d. Data signed	(Month, Day	, Year)
	(5_	40			1110		Jan 17	200	0

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFH G779 1/19/2000 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 2200m THOMAS JK. JOHN anuary 16, 2000 JAMES · /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) Examiner Baltimore City naryland General 40spital If Under 24 Hrs. 8. Dete of Birth
Hours | Min. (Month, Dey, Year) 5 Security Number If Under 1 Yeer Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Deys 218-20-0043 12 M 2 F Yrs Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 25s-1 shot traumstic event, the Medical Examiner must be notified at 1X Yes 2 □ No NIA MARIKAND Directo 10e. Street and Number 10g. Citizen of Whet Country? WOODBROOK AVENUE 21217 USA. Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stelus 1 X Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merrjed 1□ Yes 2⊠No à BLACK 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 +HGRADE SELF-EMPLOYED SKILLED CONTRACTOR Department of Health and Mental Hygi important: If them 27 is marked other 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JOHN HENRY THOMAS BLANCHE 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3511 WOODBROOK SON) AVE. BALTIHORE, MD. 21217
Date 20c. Location - City'or Town, Stete EROV THOMAS PINDER 3altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 01-24-00 OWINGS MILLS, MO. GARRISON FOREST 21. Signalus - Funeral Service Licensee

22. Name end Address of Fecility

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

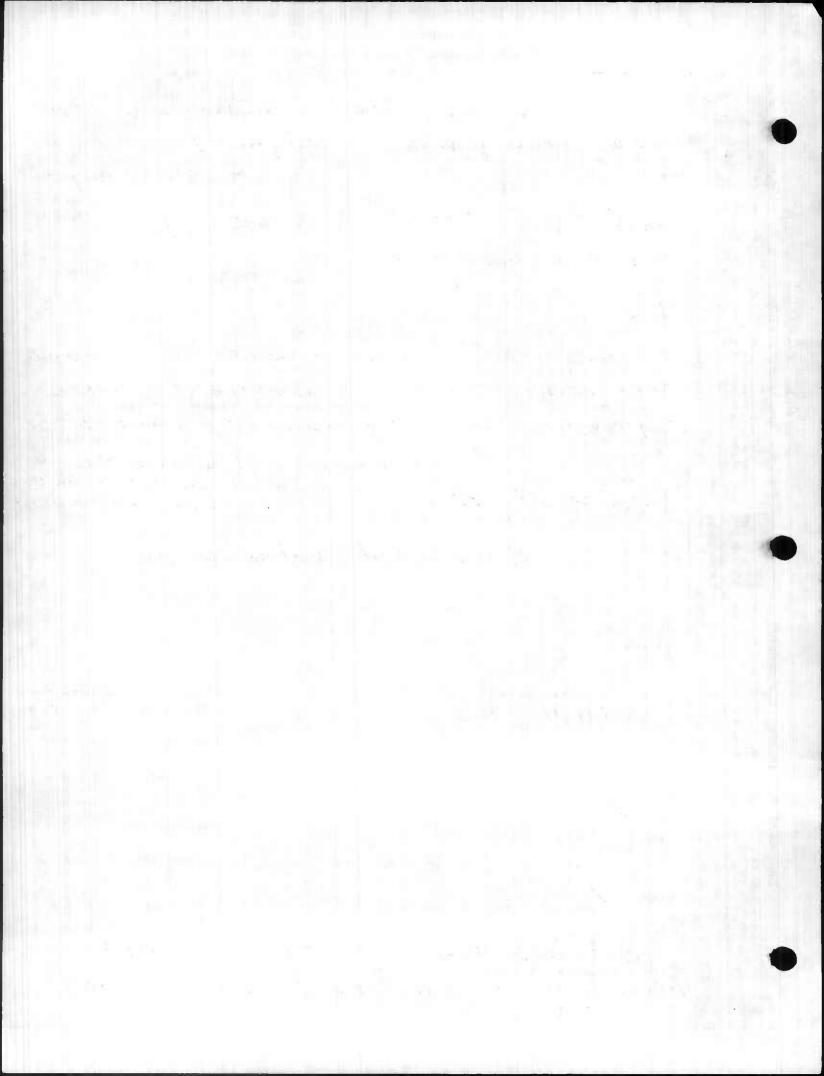
Approximate BROWN JR. FUNERAL HOME Approximate Interval Between Onset and Death **Physician** PRTERIOS CLEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Examiner ician and buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be execu physician Box 68760 Physician/Medical the Due to (or es e consequence of) 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? abetes Mellitus 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records, þ 24e. Wes en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed After this certificate has 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica 25. Wes case referred to medical exeminer?

1 Yes 20 No funeral director, Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 🗆 No Investigation 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - Al home, farm, street, fectory, office building, etc. (Specify) 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner steted. 29c. License number 29d. Detę signed (Month, Dey, Year) 29b. Signeture and title of cartified 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 9 2000 Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death VIVIAN THIVIERGE 4.10 pm JANUARY 14, 2000 4c. County of Death 4a. Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Death BATIMORE SOOD SAMAPITAN BALTMORE HOSPITAL 5. Social Sacurity Number if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 6 - 2 - 1 9 2 4 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foreign Country) Months Days 1□ M 2⊠ F Hours Yrs 219-12-7897 75 Maryland Usuat Rasidance of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits n/a Baltimore 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 S. Belnord Avenue 21224 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritai Sfatus 14. Race - Amarican Indian, Black, Whita, atc 1 Nevar Marriad 2K Married 1 ☐ Yas 2 🔼 No If Yas, Giva 1 ☐ Yas 2 ☒ No Specify: White п Yas, Giva Yaar or Datas: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Home maker In own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) John McDonald Alice Fox 19a. Informant's Name/Ralationship (Type, Print) Spouse 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 514 S. Belnord Avenue, Baltimore, Maryland 21224 Romeo Thivierge 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata 1/17/2000 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donatton 5 ☐ Othar (Spacify) 21. Signatura of Funarai Sarvica Licansas 22. Nama and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland anne 23a. Part It Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final KILATERAL PHEUMORUA disaasa or condition rasulting in daath) Dua to (or as a consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? METASTA525 1 ☐ Yas 2 No

Physician /Medical **Examiner**

that the death certificate be axecuted

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

۵

Completed

2

MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If ferm 27 is marked other than "natural", or Items 28s any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

the Maryland

with

Examiner Physician/Medical by Completed Be

ician and burial-transit physician is the burial 10 signed by I Medical Certification: To

peen has

certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director,

10

State Registrar

Sequentially tist conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 npatiant 2 ER/Outpatient 3 DOA 1 ☐ Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Dascribe how injury occurred 1 Waturat 5 Panding invastigation 2 Accidant 1 Yas 2 No 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifia:

20 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

APHAEL 601 0000 31. Data filed (Month, Day, Yaar)

29b. Signature and title of certifier.

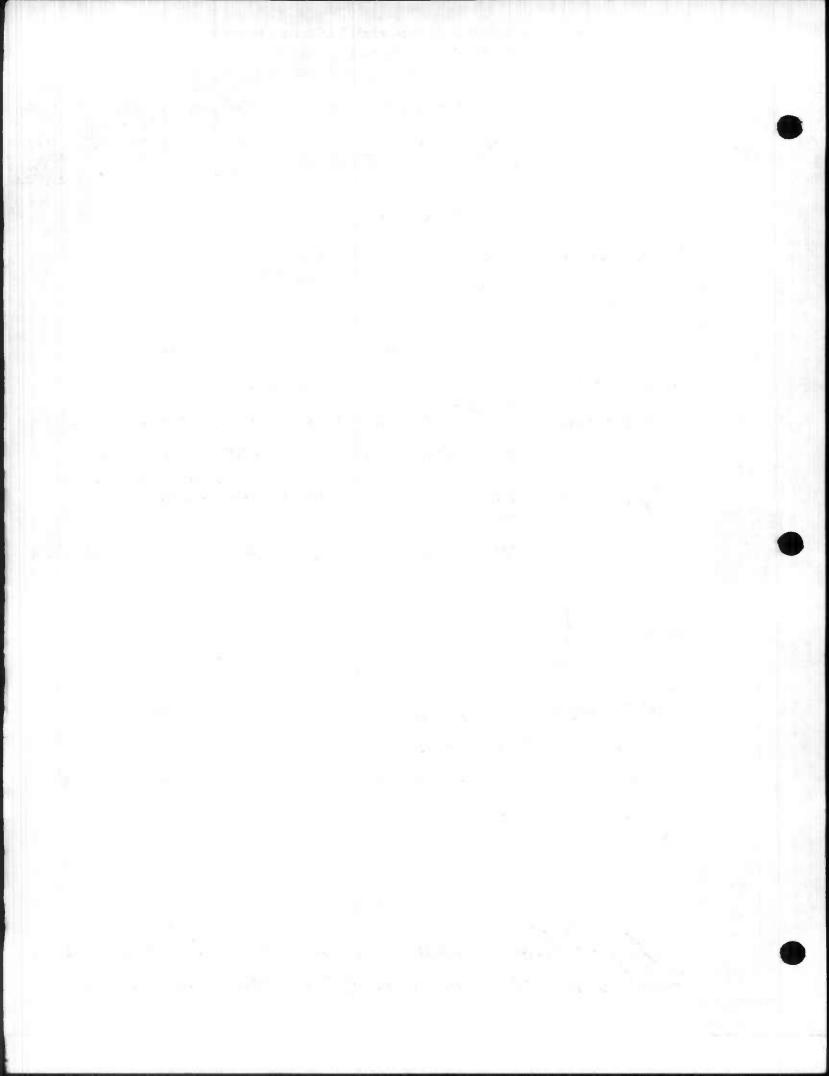
32. Ragistrar's Signature 9 2000 JAN 1

LOCH PAYEN, BILL BARTIMORE MD 21239

P12557

29c. Licansa number

29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month **Physician** January 15, 2000 10:15 AM Trotta Gerald /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deaton Specialty Hospital and Home Baltimore if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral №** M 2□ F Months Deys Dec. 6, 1906 **Director** Italy 219-07-1606 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits 1 TYPes 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be United States 1 West Conway Street Apt. 1214 21201 death Funeral 14. Race - American Indian, 12. Was Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □XYes 2 □ No 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Barber 12 7 la marked other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be and Mental (Not Known) Archangela Eelice Trotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 8m 27 I Baltimore, MD 21214 permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other th Mr. Raymond Trotta / Son 4503 Walther Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetton 5 XOther (Specify) Entombrent Moreland Memorial Park 1/18/2000 Baltimore, Maryland Timothy Harman Leonard J. Ruck, Inc. Funeral Home I Service Licensee 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the diglesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS DAYL disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner DISTEOMYELITIS physician and the buriel-transit be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of) 68760, Physician/Medical Due to (or es a consequence of): Box 980 signed by the a 23b. Did tobacco use contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No HUPERT ENSIGN that Division of Vital Records, à 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? COMMESTIVE HEART FAILURE s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Naturel 5 Pending death. 1 Yes 2 No investigation 2 Accident ofter death Director: / 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital or within 24 hours eft To the Funeral Dis completely filled in 29a. Certifier i Cretifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 47945 January 15, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUARE DAINE BACTIMORE MM 21237 HARIS ACEEM MD 9101 FRANKLING 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

IAN 19 2000

0

2000

M

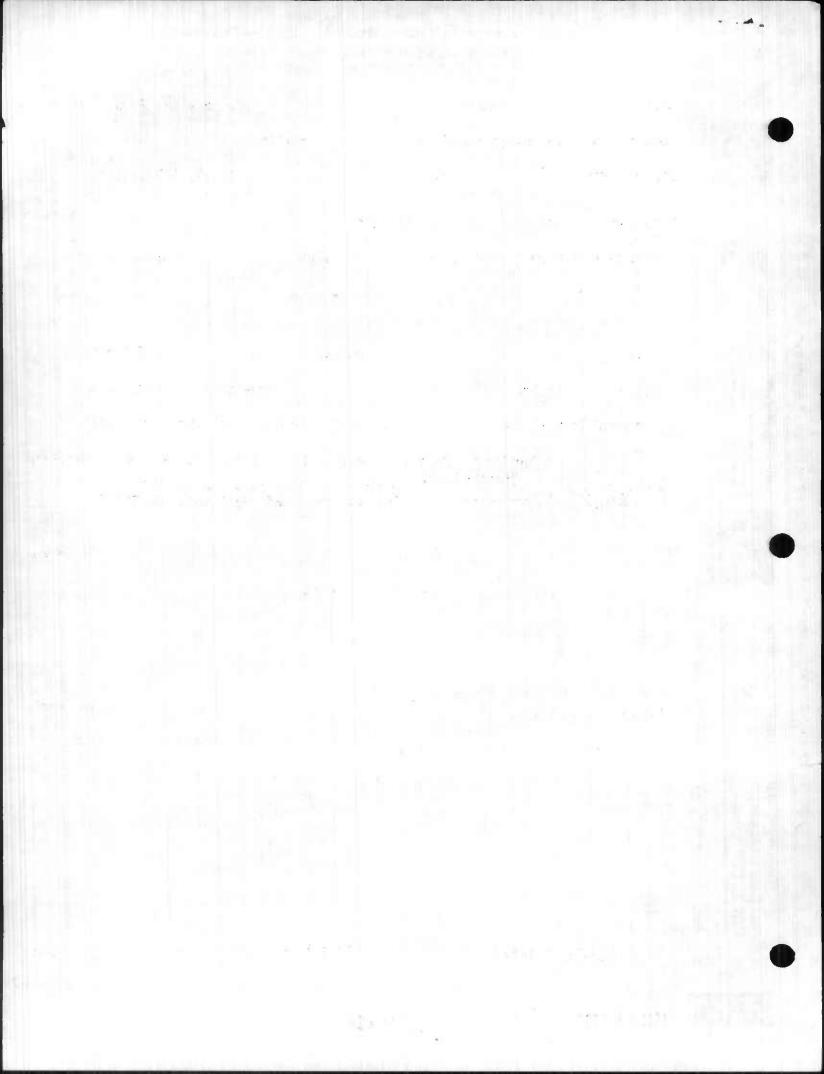
K

って

K

KOT

CKALD



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name /First Middle Last) 3 Time of Death Month **Physician** 15, 2000 4:15 AM January Joseph Frank Taylor, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 3737 Chestnut Road Bowleys Quarters Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Funeral Days Min 10XM 20 F Yrs. 1917 82 Maryland Director 215-12-8884 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21214 United States 3302 Echodale Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 X No Specify: Specify: Aq White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) and Mental Is marked of should be Margaret Langdon Bernard Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health them 27 i Baltimore, MD 21220 Mr. John Taylor / Nephew 421 Carrolwood Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 XBurlal 2 Cremation 3 Removal from State 1/18/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee Timothy Harman 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** SUDICE CARILIDE

Due to (or es e consequenca of): /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. NU(TIV 1000 1 Yes 2 No 3 Probably W Unknown Q CUNUMIC A ENAL PAIL 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy MENTENSION Sisters ial or Attending Physician: These after death.

In Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t Wetural 5 Pending investigation Injury N S1 1 A. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

of Vital Records,

Division To the Hospital o within 24 hours at To the Funeral D

Registrar

filled in by

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

3 Suicide

29e. Certifier (Check only one)

4 Homlcide

29b. Signature and little of certifier

31. Date filed (Month, Dey, Year)

JAN 19 2000

LUCH 32. Registrar's Signatur

moo (MI)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

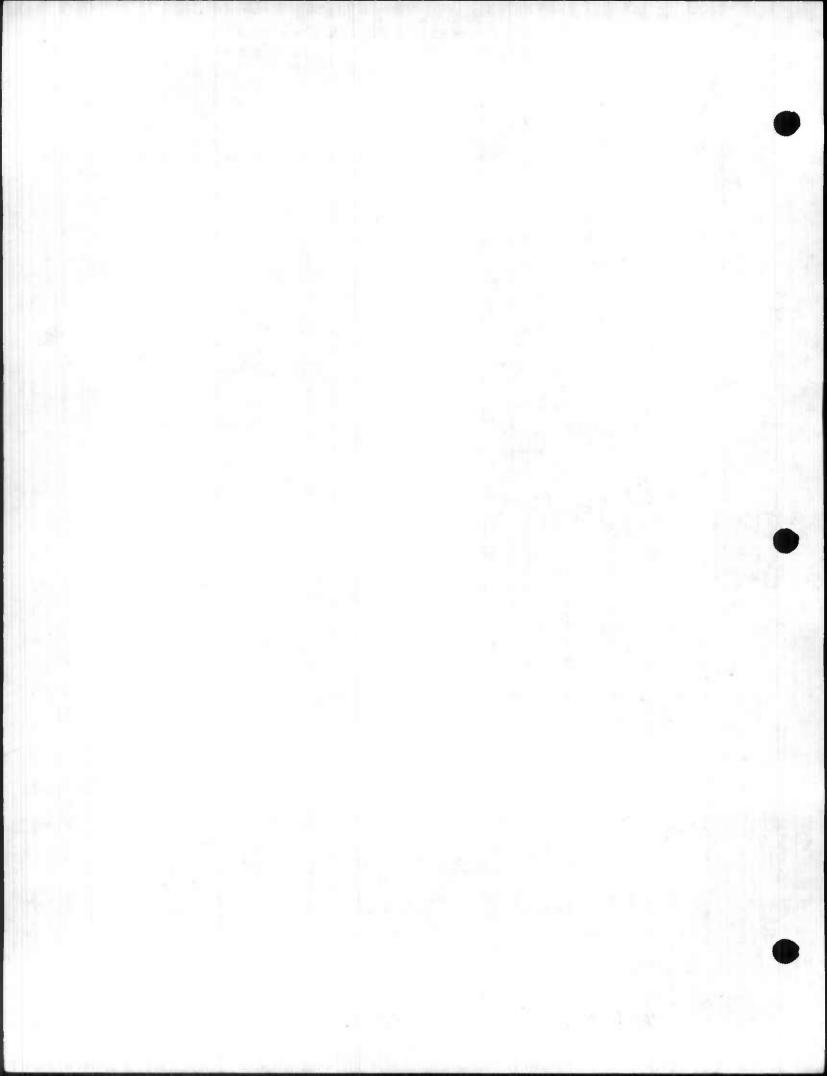
| Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date #gned (Month, Day, Year)

DHMH 16 Rev 6/95

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #5 PER FH G780 2/4/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:10 AM KATHLEEN VICTORIA TURNER 4b. City, Town, or Location of Death 14c. County of Death 15, 2000 /Medical 4e Facility Nema (If not institution, give street and number) Examiner STELLA MARIS AT MERCY HOSPITAL BALTIMORE 5. Social Security Number 3960 6. Sex If Under 1 Year 8. Data of Birth (Month, Day, Year) 9-26-52 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD . **Funeral** 10 M 20 F Months Days Hours Min Yrs. 217-54-3660 47 Director Usuai Residence of Decedent 10a Stete 10c City Town or Location 10b. County 10d. Inside City Limits 1 No 2 No Director MD. N/A 28a-1 BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 2241 AISOUITH ST. 21218 home 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, epecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Merried "natural", or Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 No Specify: à 3 ⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b Kind of Business/Industry d 2 should be flied within 73 th and Mental Hygiene. 7 is marked other than "ne (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) -12--0-CASHIER FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) UNKNOWN MAZIE SICIPIO 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) KATHLEEN V. TURNER (DAUGHTER) 2241 AISQUITH ST. BALTIMORE, MARYLAND 21218 Department of Health reportant: if Item 27 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Pages 1 K Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1/19/2000 BALTIMORE, MARYLAND MT. ZION CEMETERY 4 Donation 5 Other (Specify) 22. Name end Address of Facility REDD FUNERAL SERVICE 21. Signature of Funerel Service Licens Lealo 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heer feilure. List only one ceusa on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Finei diseese or condition resulting In deeth) /Medical Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 88 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hoapital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 26. Place of Death (Check only one) StellA MARIS MERC Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSpice 1 Yes 2 Yo Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28a. Deta of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of edicai Certification: Injury 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Piece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide

State Registrar

DHMH 16 Rev 6/95

29a, Certifier

29b. Signetura and title of certifier

30. Nema and addrass of person who completed cause of death (ttern 23a) (Type, Print)

2000

St Aul

301

72. Registrar's Signature

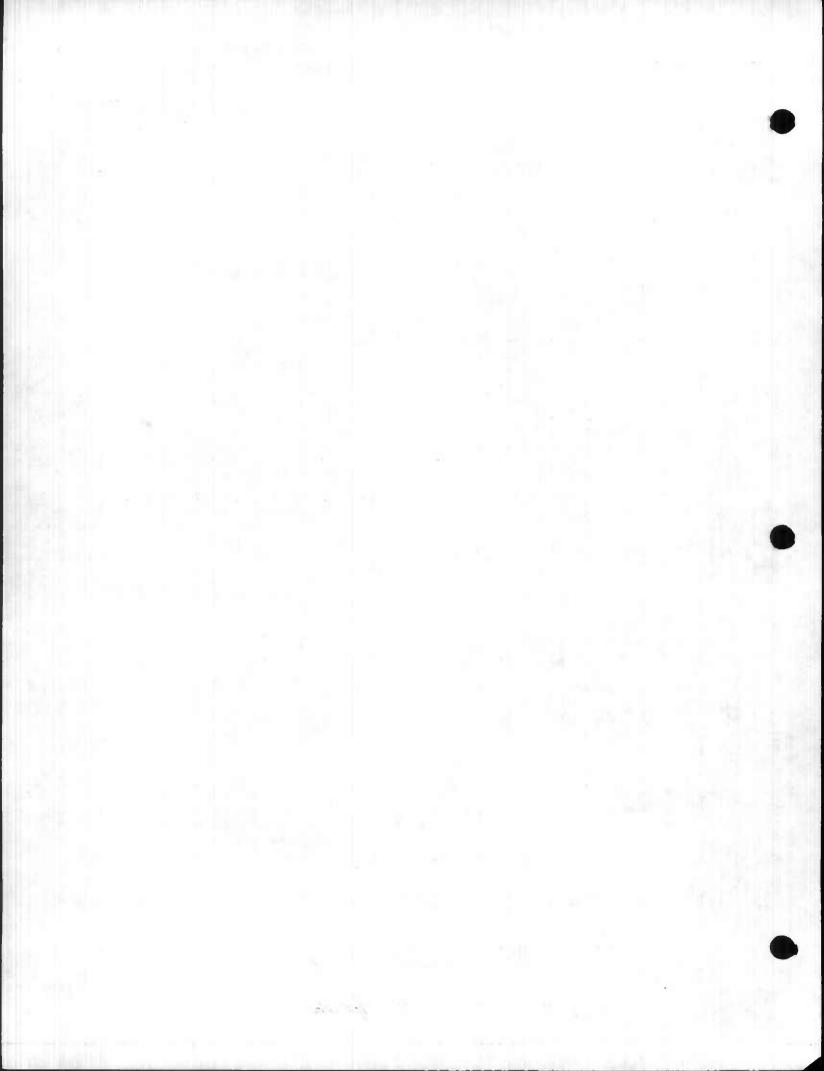
Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORR



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #23a PER MD G779 1/19/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician 6:15pm CATHERINE ISABEL UMPHLETT JAN. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 419 Lorraine Ave. Essex Baltimore Birthplace (State or Foreign Country) If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 8. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Min 1 M 2 X F Yrs. 55 Director 218-42-3672 Oct. 21 1944 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Balitmore 1 Yes 2 No Director Essex must be notifie or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Lorraine Ave. Herna 23e 21221 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Stetus hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 210 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced natural, Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flad within 72 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10th own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked Frank George unknown 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If them 27 is say injury or other tree once. Charles Umphlett /husband 419 Lorraine Ave. Baltimore Md. 21221 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ₩Buriel 2 Cremetion 3 Removal from State Holly Hill Cemetery 1/5/2000 4 Donetion 5 Other (Specify) Baltimore Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MACE AVe. Baltimore Md. 21221 not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in deeth) /Medical Troke Examiner Due to (or as a consequence of) Examiner ATHEROSCLEROSCLEROSIS physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as e consequence of): attending ed by the a signed by t þ Completed Be

Division of Vital Records, edicai Certification: To this or Attending To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Pert If. Other algnificant conditions	contributing to death but not re	esulting in the underlying	cause given in Part f.	23b. Did tobacco use co	ntribute to the cause of death?		
COPD		1 → 10 No	1 2 No 3 Probably 4 Unknown				
Alcoholi	liver	disea	se	24a. Was en autopsy parformed?	24b. Were autopsy findings available prior to completion of cause of death?		
25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)						
	Hospitel:	☐ ER/Outpatient 3☐	Home 5 PAesidence 6 □Oth	ne 5 Residence 6 Other (Specify)			
1 Yes 2 No	1 Inpatient 2						
	28a. Date of fnjury (Month, Day Year)	28b. Time of	28c. fnjury at Work? 1 Tyes 2 No	26d. Describe how injury occur	red		

0 State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certification - un

30. Nema and address of parson who completed cause of deeth (Item 23a) (Type, Print)

MICHAEL MARTIN, MD

31. Date filed (Month, Dey, Year) JAN 1 9 2000 32. Registrer's Signeture 22 person



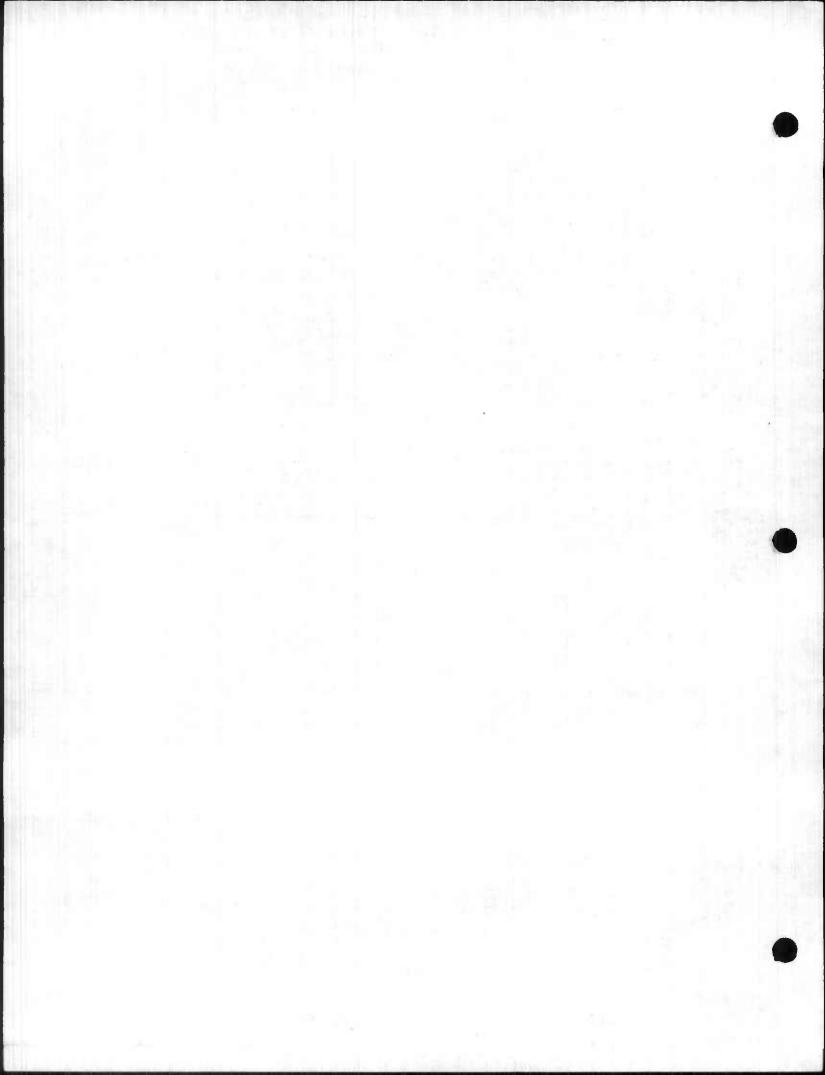
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 2000 Month **Physician** 3:50 am anuans Elizabeth Williams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore City Mospital Mul If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Hours 85 Director V.A. 226-18-2415 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 Yes 2 No Director Baltimore Co. MD Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3712 Crossleight Ct. 21133 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Fatient Known $0.8\,E$ / Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic avent, the Madical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Private 6th grade Domestic 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Robert Lee Williams Jonnie Long 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nephew Department of Health a Important: If item 27 is eny injury or other tra Carroll E. Pearl Sr. 3712 Crossleight Ct. Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, cremetory or other place) Method of Disposition

Method of Disposition

Removel from Stete 20c. Location - City or Town, Stete 4 □ Donation 5 □ Other (Specify) King Memorial Park 1/21/2000 Randalstown, 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, 21215 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or hear feilure. List only one cause on a line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner sician and buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Box 68760. Due to (or as a consequence of) signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 ∑Unknown Records, þ The faw requires 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? Completed completion of causa of death? page 2 1 Yes 2 No 1 Yes 20 No Division of Vitai or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 1 D Netural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williams vances 32. Registrar's Signature State Registrar 9 2000 **DHMH 16 Rev 6/95** 부분명 c c 2004

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 9 2000 4c. County of Deeth Philip H. Weber 4b. City, Town, or Location of Deeth 9:50 PM 4a Fecility Neme (If not institution, give street and number) Talbot Genesis Elercare- The Pines Easton ff Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Dec 30, 19 If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 □ F Months Deys Hours Min 64 Yrs 219-30-5393 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Talbot Easton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21601 610 Dutchman Lane 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown 17. Fether's Neme (First, Middle, Last) unknown sheet metalist Name (First, Middle, Meiden Sunname) ndustry Philip Weber Verna May Harris 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Brenda Gellert/sister 2725 Cecil Drive Chester, MD 21619 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☑ Other (Specify) in state 21. Signature of Funerel Service Licensee Rohald S. Wade , Director $^{22.\,\text{Name and Address of Fecility}}_{\text{State Anatomy}}$ Board 655 W. Baltimore Street LILL 21201 Baltimore, MD Kin 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, k, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel Cancel disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 - 108 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) exeminer? Other: Dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

physician and s the burial-trans certificete be exec Box 68760 Division of Vital Records, P.O. Attending Physician:

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

9

Completed

Be

P

Certification:

Medical

4 Homleide

(Check only one)

29b. Signature and title of contiti

29e. Certifier

Funeral

Director

7 is marked other than "natural", or itema 23e or 28a-f show trsumatic svent, the Med cal Examiner must be notified at

with the Meryland

Pages 1 and 2 should be filed within 72 hours efter deeth

el Hygiene.

Mentel

permit. Pages 1 end 2 should be Depertment of Health end Mentel Important: If Item 27 is marked in

Injury or

eny In

Physician /Medical

Examiner

98

Philip Weber Baltimore, Maryland 21215-0020

188 Por signed by the e peen hes page 2 certificate director. this funeral After efter deeth. Director: Aff 6 n 24 hou. Funeral D Hospital To the within 2

> State Registrar

MD 32 Registrer's Signeture How

end menner steted.

30. Nema and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

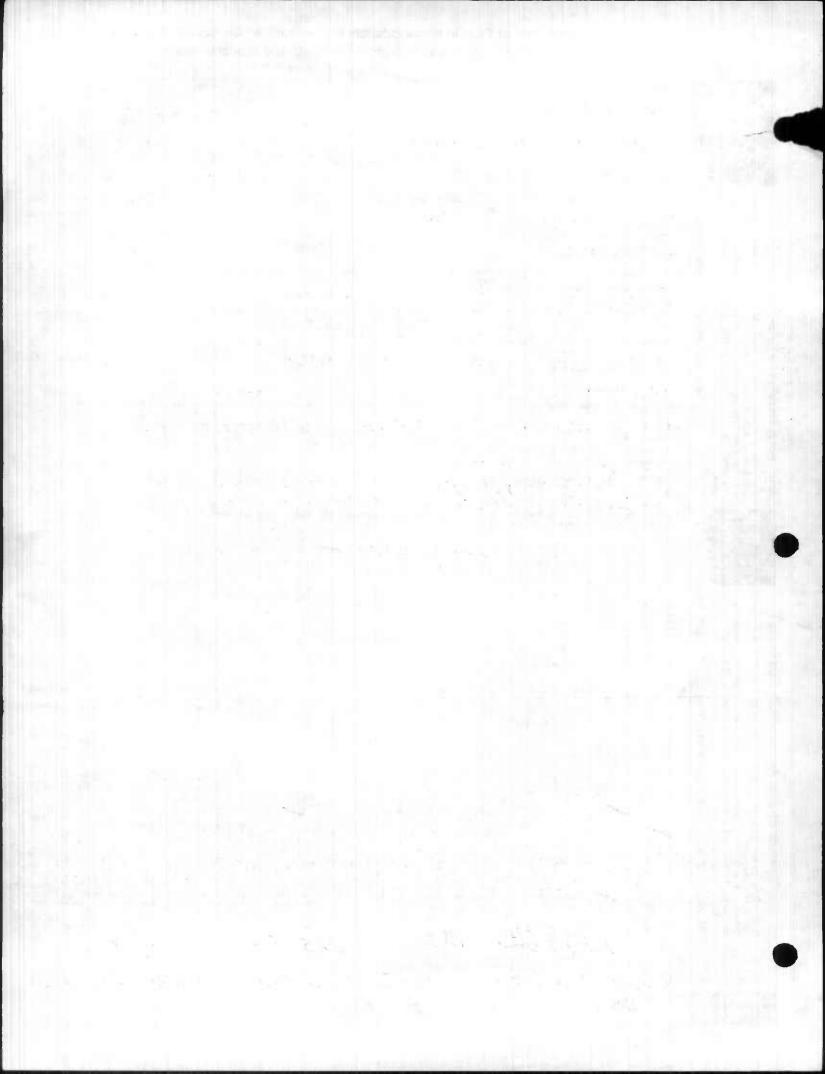
508 IDLEWILD AVENUE

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dav Year Month **Physician** Herbert Augustus Wright
4a Facility Nama (Ill not institution, give street and number) 2000 0 :40 AM 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL SECOURS BALTIMORE if Under 1 Year 7. Aga (In yrs. last birthday)
Yrs. If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** Months Days 216-09-2932 1M 20 F Director MARU Usual Residence of Dacedant t0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Yes 2□No Director 28a-f MARYLAND 10e. Street and Number 10f. Zip Code 10g. Offizen of What Country? b must be FAVETTE STREET 2122 Norms 23a USA. Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1⊠ Yes 2 □ No If Yes, Giva Yaar or Datas: WW ∏ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: BLACK ğ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiens. Elemantary/Secondary (0-12) Collega (1-4or 5+) CLERK SOCIAL SECURITY ADM UNKNOWN permit. Pages 1 and 2 should be file.
Department of Health and Mentai Hy, important; if New Z7 is marked other any Injury or other two 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be UNKNOWN UNKNOWN 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1519 TUNLAW ROAD, BALTIMORE, MD, 21218
Data 20c. Location - City or Town, Stata NATALIE WRIGHT (GRAND-DAUGHTER) 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata N-21-00 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) ALTIHORE NATIONAL 22. Name and Addrass of Facility 21. Signature of Eunaral Sarvice Licensee JR. FUNERAL HOME EPH JOS 2140 N. FULTON AVE., BALTIMORE, MD. 2121 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory e shock, or haart tailura. List only one cause on each line. **Physician** /Medical Immediata Causa (Final 24 hor. disaase or condition rasulting in death) Examiner Examiner physician and the bunal-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Mellitus þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was casa refarred to medical exeminar? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Matural 1 Yes 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 1) 22342

State Registrar Michael

31. Data filed (Month, Day Year) 9

DHMH 16 Rev 6/95

m.D.,

2000 W.

Balvinore St., Biffinere, Md. 21223

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

N.

Rubinstein, M.

Denevas



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rohert £. Whiteman January 15, 2000 7:30 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2008 Letitia Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** NOM 20 F Months 79 106-14-5954 Yrs. Director Jan. 5, 1921 New York Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Ø Yes 2 □ No Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "netural", or items 23a the Medical Examiner must b 2008 Letitia Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U,S. Agned Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiene. ther then Elementary/Secondery (0-12) College (1-4or 54) parmit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If them 27 is marked other th any Injury or other traumatic event, the Communications U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Jesse L. Whiteman Ethel L. Barnhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Betty R. Whiteman/ Wife 2008 Letitia Avenue Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Vet. Cem. Crownsville1-19-2000 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Neme and Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Maryland 21229 uanda Homos 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Betw **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-tran Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tabetes Physician/Medical Due to (or as a consequence of) artery direase Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown Septicenuo þ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? Completed 1 Yas No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes Z No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number rus meleta MD 39030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AnnapolisRd

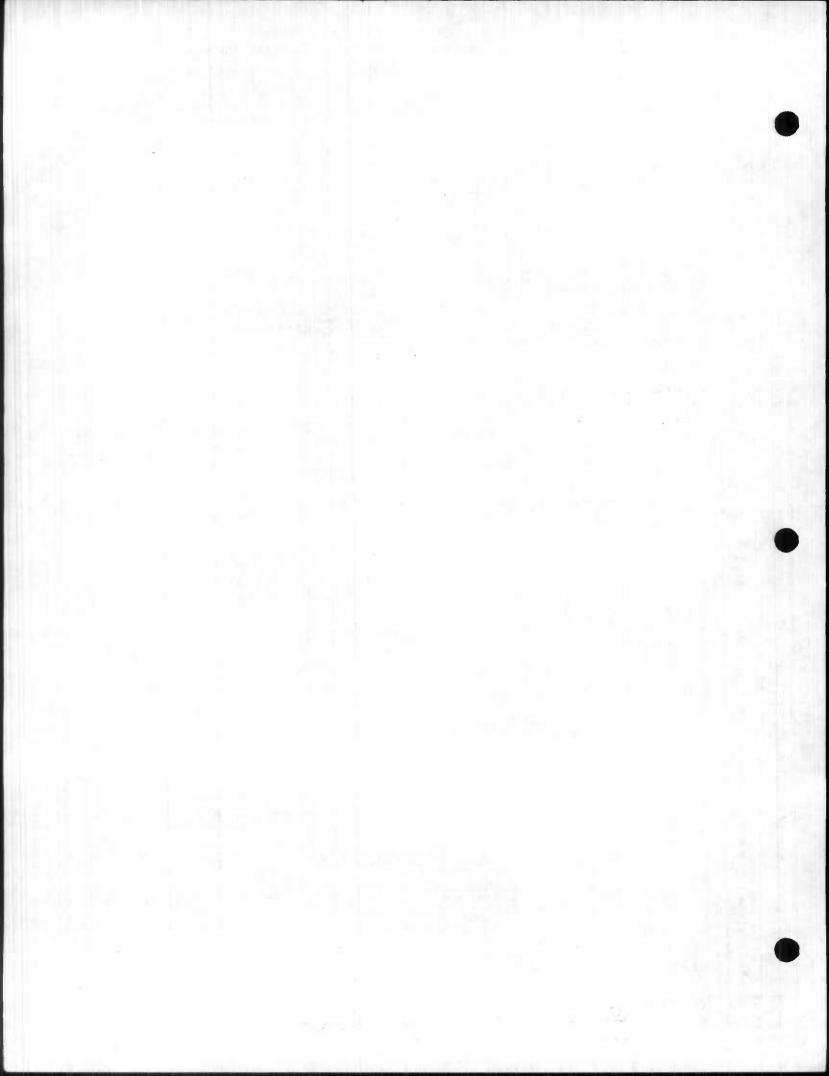
State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

JAN 1 9 19

32. Registrar's Signature 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month Day Physician Joseph Williams 9:50 PM January 16 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medial Conter Baltimore If Under 24 Hrs. 8. Data of Birth Hours Min. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplaca (State or Foraign Country) **Funeral** Months 10 M 2□ F Days Director 219-10-0542 76 May 31,1923 Maryland Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits met be notified at 1 ♥ Yas 2 No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiena.
Int: if Item 27 is marked other than "natural; or items 23e or lary or other traumatic avent, the Medical Examples must be 1. 5617 O'Donnell Street 21224 Funeral United States 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whila, atc. 1 ⊠ Yes 2 □ No If Yes, Giva Year or Datas: 1 ☐ Nevar Married 2 ☑ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 6 furniture maker furniture Baitimore, Maryland 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) John Garfield Mary Edith Shockley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 229 Fourth Avenue, Lansdowne, Maryland 21227 Mabel V. Milburn - sister 20a. Method ol Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from Stata permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) Loudon Park Cemetery 1/21/00 Baltimore, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 23a. Part1. Enter the disease, or confpications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart lailure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final Coronary antery disease one month disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pul Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 88 188 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown fibrillation 1 ☐ Yee 2 ☐ No atrial of Vital Records, Completed by 24b. Wara autopsy lindings available prior to completion of cause of death? diabetes mellitus (Type 2) 24a. Was an autopsy performed? 2 A No 1 Yas 1 Yas 2 No certificate Attanding Physician: 25. Was casa referred to medical axaminar? 8 26. Place of Death (Check only ona) 1□ Yas 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA this funarai 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury After 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Natural
2 Accident 5 Pending invastigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Michael Westerman M.D. D52451 January (7 2000 30. Name and addrass of person who completed causa of death (ttem 23a) (Type, Print) Michael Westerman M.D. Johns Hopkins Geviatrics Center 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JAN 19 2000 Registrar

THE

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month White, Sr. 16, 2000 Charles January 11:45PM 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5504 Willys Avenue Baltimore Baltimore if Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Devs M M 20 F Hours 219-01-7672 81 Yrs Nov. 4, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5504 Willys Avenue 21227 United States 12. Wes Decedent Ever in U,S. Armed Forces?

**VAX'es 2 □ No if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electrical Engineer Manufacturer 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Charles W. White Ann Bayer 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Dorothy A. Canter/ Daughter 535 Arundel Blvd. Crownsville, Maryland 21032 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) Most Holy Redeemer Ceme. 1/20/2000 Baltimore, Maryland 22. Name end Address of Facility 21. Signeture of Funeral Service License Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 Part Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth ACUTE MYOCARDIAL INFARCTION 1 HOUR Immediete Cause (Final disease or condition resulting in death) Due to (or as e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was casa referred to medicel exeminer? 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

Examined The law requires that the death certificate be executed Box 68760. P.O. Records. Division of Vital Physician: or Attending Hospital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Express

Physician

/Medical

sician and burial-transit

physician s the buria

signed by the all

page 2 s

Phis funeral

After

the

filled in by

24 hours after death.

88

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical pletely

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

the Maryland

death

within 2 the state

DHMH 16 Ray 6/95

State Registrar

31. Dete filed (Month, Dey, Year) JAN 19 2000

30. Neme and address of pe

29b. Signety's and title of certifie

SALLY RUBENSTONE

FFE C C

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

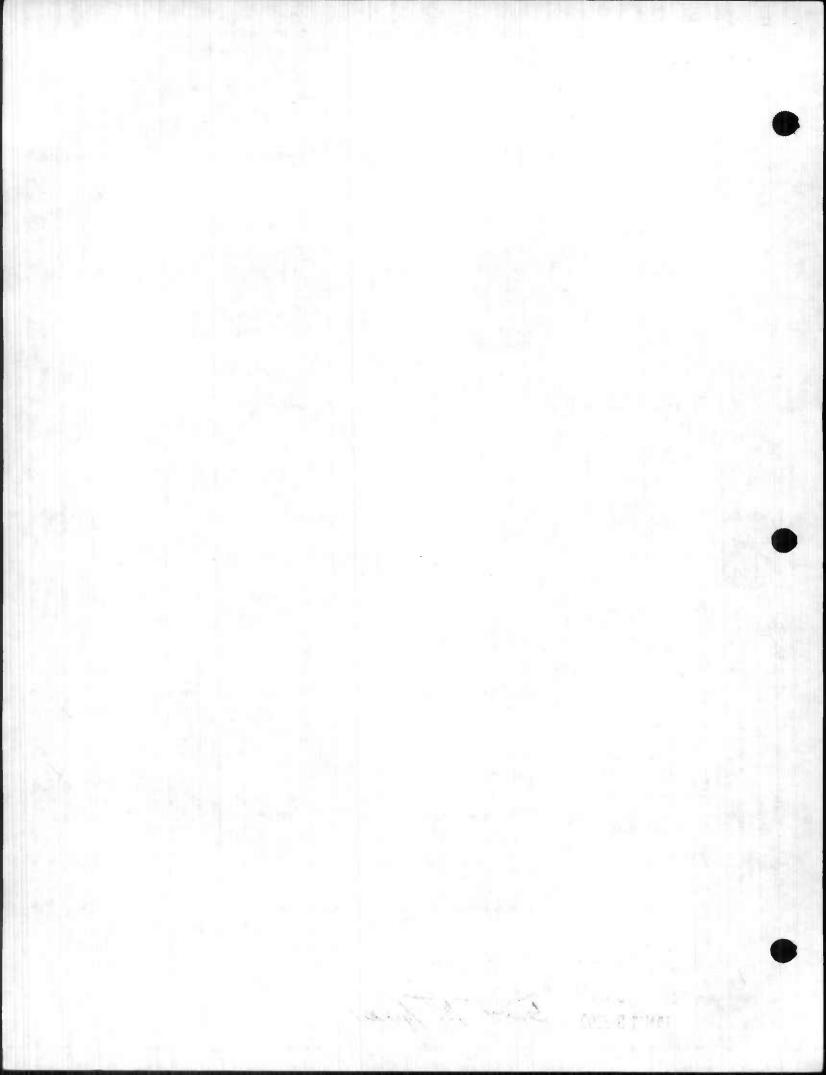
29d. Date signed (Month, Day, Year)

700 GEIPE ROAD, BALTIMORE, MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

partment of Health and Mental Hygiene	01	1115

EDNA WILL	IAMS	State of Maryland	Certificate		ental Hygie Reg.		FILEO
Physiciar /Medica	Earla	Williams				Day Year 4, 2000	3. Time of Death 10:55 AM
Examine	4a Facility Name (If not institution 167 SOUTH MOR			4b. City, Town, or Lo BALTIMORI		4c. County of Deal	A
Funeral Director	5. Social Security Number 217-38-0039	6. Sex 1 M 2 F 7. Age (In yrs. II	Yrs. If Under 1 Y Months Da	eer If Under 24 Hrs. Bys Hours Min.	8. Dele of Birth (Month, Day, You	5,1934 M	nplace (State or Foreign untry) Aryland
Mand Mand	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
vith the Mar to or 28s4 si be notified	10e. Street and Number	IA :	Batimo 101. Zip Coo	ore de	10g.	Citizen of Whal Co	1 (Yes 2 No
agh wi	161 S. N	12. Wes Decedent Ever in U.S	2	1229	sit. Vac as No	14. Race - Amer	H ioon Indian
	3, Widowed 4 □ Divorced	Armed Forces?	ff Yes, specify (of Hispanic Origin? (Spe Cuban, Mexican, Puerlo No Specify:	Rican, etc.)	Black, White	
n 72 h n 72 h n 72 h	15. Deceden (Specify only higher		16a. Decedent's Usual Oc (Give kind of work do	ccupation one during most of working offred)	ng 161	b. Kind of Business/I	ndustry
od within 72 ho ygiene. we then 'netur 4, the Medical.	Elementary(Secondary (0-12)	College (1-4or 5+)	Domes	tic	1	rivate	Family
SHOW S	17. Father's Name (First, Middle,	Chambe	rs	18. Mother's Name	(First, Middle, Mai	Eads	/
d 2 sh th and 7 is me	19a, Informent's Name/Relations	hip (Type, Print) (SISTER)	19b. Mailing Address (St.	reet and Number or Rura	Route Number, C	city or Town, State, Z	ip Code)
ditimote, mit. Pages 1 an partment of Heal portant: if Item 2 y Injury or other 66.	20a. Method of Disposition	00	ace of Disposition (Name of metery, grematory for other	place)	Date, 200	c. Location - City or	Town, Stale
t. Pag firment rlaint: II	1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	Arbutu	S "	22/2000 3	Balto.	Md.
Department of the same of the	21. Signature of Funeral Service	Lidensee	Joseph	L. Ryss	Fune	ral Hor	ne,
	23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the death only one cause on each line.	Do not enter the mode of	dying, such as cardiac of	r respiratory arrest	. Na.	Approximate Interval Between Onset and Deeth
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a <u>Hypertensive</u> Due lo (or	es e consequence of):	erotic Card	iovascula	r Disease	
be executed ician and buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or	es e consequence of):				
ficate ficate streets the	resulting in death) Last	Due Io (or	es e consequence of):				
at the death certification of the standard for use a physician of the standard for use a physician of the standard for use a st	Part If. Other signiffcant condition	ns contributing to death but not resu	iting in the underlying cause	e given in Part f.	23b. Did toba	cco uae contributs	to the cause of death?
					1 □ Yes	2 No 3 Pr	obably 4 Unknown
been signification of the property of the prop					24a. Was an a performe	d?	Were autopsy findings available prior to completion of cause of death?
= F # 6 C					1 ☐ Yes	2 X No	□ Yes 21 No
Physician: The Physician and director, page 170 Be Co.		Hospilal:	SP/Outration 27 DOA	26. Place of Dealh Other:		e Dothas (Cas	nife)
After this funeral d		28a. Date of Injury (Month, Day Year)	28b. Time of fnjury M		28d. Describe how	e 6 Other (Specification of the Injury occurred	(cny)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 Suicide 6 Could determ		me, farm, street, factory, of	fice	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
To the Hospital or An within 24 hours after of To the Funeral Direct completely filled in by Medical Certifil	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of my know Examiner: On the basis of examinati and manner stated.					
To the Within To the comple				cense number	29d	. Date signed (Month	Day, Year)
	Theorle	of Kirk rus		O.C.M.E		JAN. 14,	2000
8	- 1 - 1 - 1 ·	who completed cause of death (Item /2	23a) (Type, Print) L Penn Street	t, Baltimore	e, Maryla	nd 21201	
State	31. Date filed (MoMh, Day, Year)	S2. Registrar's Signer	la V	i l		-	
Registrar	IAN 1 9 2000	100	Mours				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#17 PER F.H. G779 1-26-2000 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Merle Wilt 2000 Jan 17, 1:00am /Medicai 4a. Fecility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore N/A 5. Social Sacurity Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month, Day, Jan 2, 9. Birthplaca (State or Foreign Months Days Hours X□X M 2□ F 1930 70 Baito, MD 217-24-4112 Yrs. Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md N/A Baltimore Director XX Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21211 3100 Chestnut Avenue U.S.A. Funeral Was Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 ☐ Never Married XXX Married 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Truck Driver Teamsters 6th 17. Father's Name (First, Middle, Last)
GILBERT L
James Wilt 18. Mother's Name (First, Middle, Maiden Surname) Be MAry 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gladys Wilt (Wife) 3100 Chestnut Ave. Balto, MD 21211 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, crematory or other placa) 20c. Location - City or Town, State X Buriai 2 Cremetion 3 Removal from State Dulaney Valley Memorial 1/20 4 ☐ Donetion 5 ☐ Other (Specify) Cockeysville, MD 21. Signal 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Rd. Balto, MD 21211 anter the mode of dving, such as cardiec or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardlec or shock, or heart feilure. List only ona causa on aech line. Approximate Interval Between Onset and Daath Immediate Cause (Finel CARNIO GENIC Showdisease or condition resulting in deeth) 36 hours Due to (or es a consequence of) Conston yoyat 15 chanic Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in daeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Tos 2 No 3 Probably 4 Unknown Diaheles p 24b. Were eutopsy findings aveileble prior to completion of causa of death? 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1- Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not ba 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred et the time, date end pieca, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D31976

Registrar

Funeral

Director

28a-f show ms 23a or 28a-f short rough be notified a

5

"natural",

I Hygiene.

h and Mantal F is marked ott

nt of Health e If Item 27 is or other tra

Department of important: If any injury or

Physician /Medical

Examiner

and buriel-tran

signed by

After this certificate

filled in by the funeral

of or Attending Physicien: efter death.

To the Hospital o within 24 hours of To the Funeral Di

the

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Pages 1 and 2 should be

other

other traumatic event, the Medical Examiner

the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

State

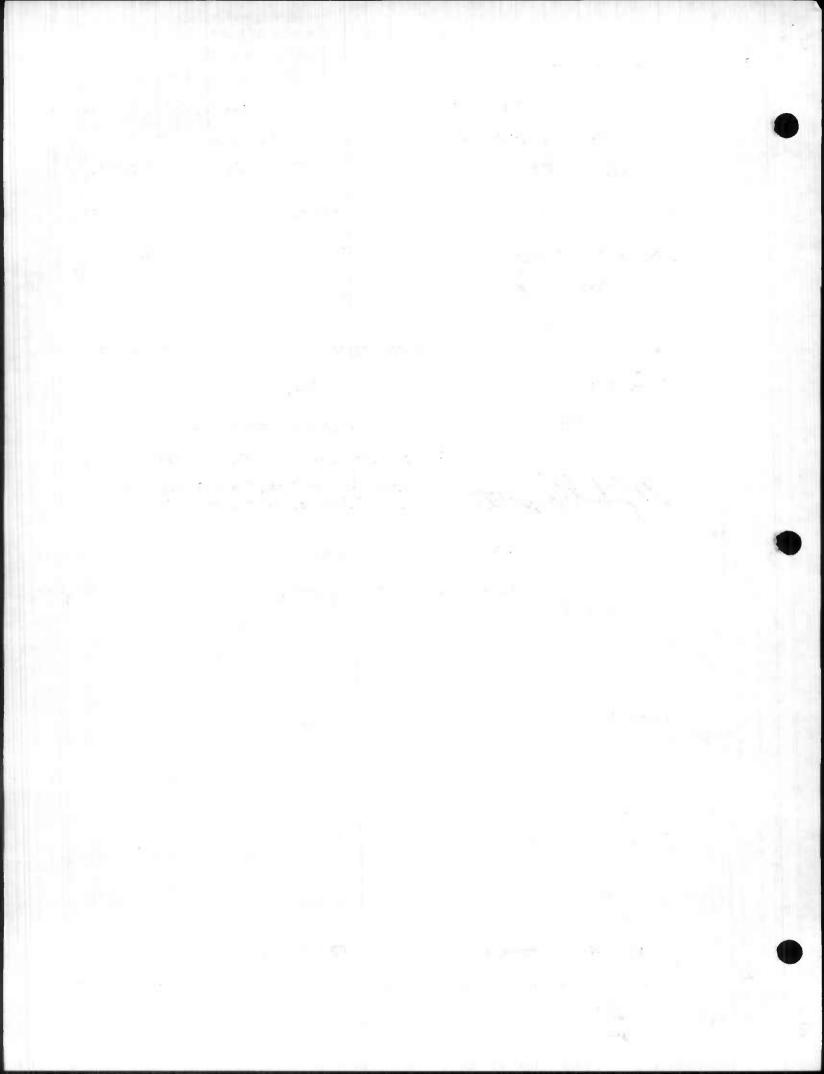
31. Date filed (Month, Day, Yeer)

DAVID SCHAMP mD 32. Registrar's Signature

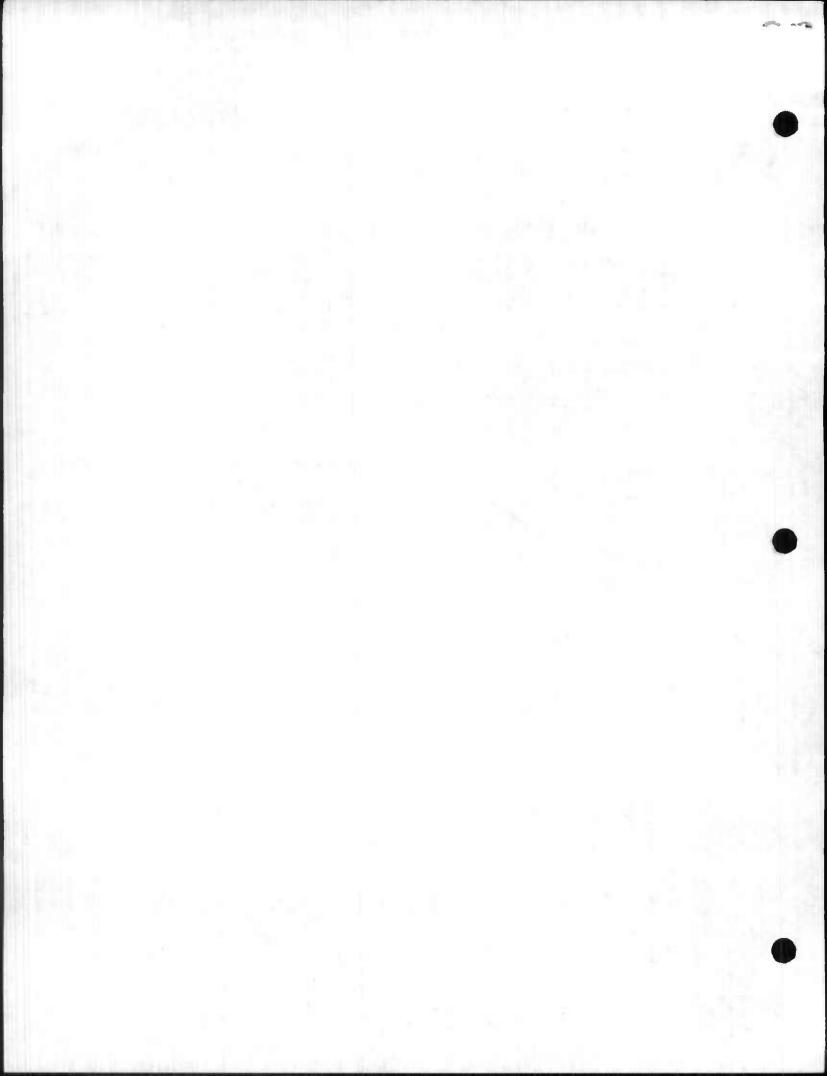
30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

ST B. Himmy, MP

200



---Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** BERYL B WILLIAMS 8:SS AH MYC 2000 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) CALIFORNIA AVE BALTIMORE Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 212-12-1122 VIECTINIA Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Directo MD PARKVILLE BAUTMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 238 21234 .S.A Funeral 3113 ALIFORNIA AVE 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, atc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: filed within 72 hours after 1 Never Married 2 Married 6 Maryland 21215-0020 1 Yes 2 No Specify: by 3 DWidowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10 DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) le marked of Pages 1 and 2 should be PAYMOND POSTON SALLIE BROOKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 le any Injury or other tre obce. N.W. WASHINGTON, D.C. 20008 3215 ELUCOTT ST. RAYMOND POSTON JR Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date JAN 18. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE MD. 7000 GARDOUS OF FAITH (EM 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNEEAL CITAPEL 1200m 23a. Back. Enter the disease or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, indick, or heart failure. Use only one cause on each line. PARKVILLE, NO 21234 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition rasulting In death) /Medical MI Acute Examiner Due to (or as a consequence of) Physician/Medical Examiner Heart The law requires that the death certificate be executed use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Box 68760, Due to (or as e consequence of) P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed 1 Yes 20 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□ Yes 2□ No Certification: To After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29c. License number 29b. Signeture and title of confiden 29d. Dete signed (Month, Day, Year) 2000 D0039297 30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print) 2314 E. JOPPA RD. BALTIMORE. 21234 MICHAE Ro, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** owic Indrew 1521 3000 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Medical (enter Baltimore If Under 1 Year If Under 24 Hrs.

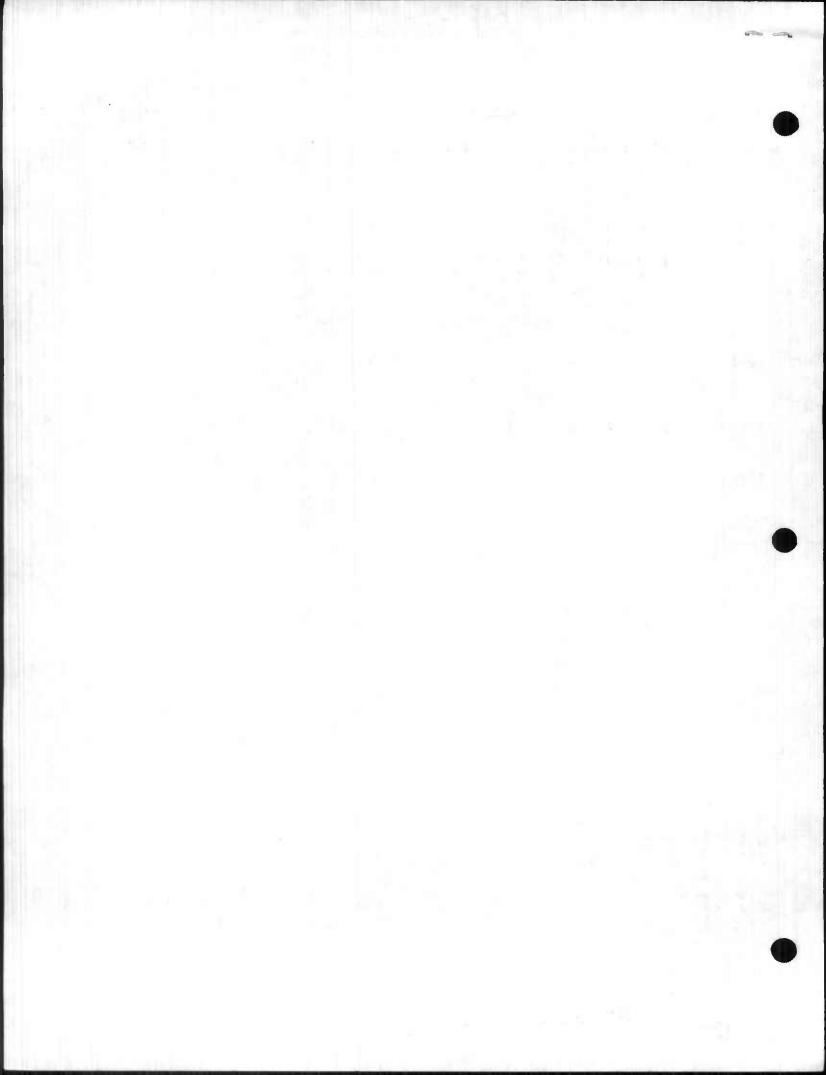
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 11916 Director 365-10-0724 100. **Usual Residence of Decedent** death with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits pernit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hyglens. Important: If flem 27 is marked other than "natural", or flems 23s or 23s-f show with fujury or other treumatic event, the Medical Examiner must be notified as once. 1 Yes 2 No Director ars altimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? urbag Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 2 ves 2 No
11 Yes, Give
Year or Dates: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No white Specify. Specify: py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General Dynamics Elementary/Secondary (0-12) College (1-4or 5+) Millwrite 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Wojtowicz Mary 2 CUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place) M. Jones-Wostavia White Marsh, MDZ1236 104 20a. Method of Disposition Date 20c. Location - City or Town, Stete Jan 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Evans Finerallhapel-bal Ai P.A 2000 Forest Hill 22. Nome and Address of Facility Evans Chapel of memories 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 8800 Harford Rd. Baltimore, mD eathe 21234 Approximate Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner color sician and burial-transit or Attending Physicien: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician at the burial Box 68760. reimers Physician/Medical Due to (or es a consequence of): USB 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. been signed by the should be detached 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 2 No 1 Yes certificata Division of Vital funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No a Funeral Director: A piately filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical To the Hosp within 24 hor To the Fune completely fi ner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 D0050624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Johns Hopkins Bay view Medical Center Baltimore MD 21224 Eastern Pay, Year) N 1 9 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 162

			Certificate of Death	mornar r	Reg. No.	0 1	L. J. Go.
	Dhuala		1. Decedent's Name (First, Middle, Last)	2. Date of I		Year	3. Tims of Deeth
0	Physic /Medi		Amelia H. Whaesen	Jan	. 16 2	000	8:20AM
4	Exami	ner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or	Location of De	ath 4c. County	of Death	0.0
-	Europal		5. Sociel Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs		Birth	9. Birthplac	OP Q ce (State or Foreign
	Funeral Director		30to -42-8819 1□ M 29 F 75 Yrs. Months Deys Hours Min. Usuel Rasidance of Decedent	Feb 1:	3 1924	PLMM	sylvania
	how		10a. State 10b. County 10c. City, Town or Location		De 3-2	10d	. Inside City Limits
	the Marylar 28a-f show	ctor	Md Baltimore Parkville		_		1 ☐ Yes 2 No
	s 1 and 2 should be filled within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or ferma 23s or 28=4 show other treumatic event, the Medical Examines must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 21234		10g. Citizen of V	What Country	?
	heme heme	uner	11. Meritel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (5 lf Yes, specify Cuben, Mexican, Puer	Specify Yes or I rto Rican, etc.)	No- 14. Raci Blec	a - American k, White, atc	
21215-0020	72 hours after "natural", or He	by	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Year or Dates:		Specify	Whi	Le
15-(n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of woilifia. DO NOT use retired)	orking	16b. Kind of Bu	isiness/Indus	itry
212	within lene.	d d	Elemantery/Secondery (0-12) College (1-4or 5+)		hom	Q	
	tal Hygie d other event, p	BeC	70-	me (First, Midd	la, Maiden Sumem	(e)	
yia	2 should be filed within and Mental Hyglene. • marked other than burnatic event, the M	To	Anthony Sochacki Ksie	NIa	unkno	wn	
Maryiand	12 sh h and le m reum		19e. Informent's Neme/Aalationship (Type, Print) 19b. Meiling Addrass (Street end Number or R	lural Route Nun	ber, City or Town,	Stata, Zip Co	ode)
	Health Health em 27		20a. Method of Disposition 20b. Place of Disposition (Name & cemetery, crematory or other place)	Date	20c. Location -	City or Town	o, Stele
Baitimore,	00-5		1 Burlai 2 Decremation 3 Removal from State 4 Donation 5 Other (Specify) State LANS FILE PAI Channel - Bodaic	Jan. 11	Empos:	- W. O.	o Ma
aiti	permit. Pag Department Important: I eny Injury o		21. Signeture of Fuperel Service Licensee 22. Name and Address of Facility 5	VANA F	-II WOOD	0 64	0000
m	Dep		KRISTA I WILL 8800 Hadred	Pd	Baltimo	10 1	14 21234
disc			23a-Fan1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardia shock, or heer feilure. List only one ceuse on each line.	c or respiratory	errest,	i In	oproximete itarval Batween
	Physician /Medical		Immediate Cause (Final				Inset end Death
	Examiner	П	disease or condition resulting in death)				
	P =	Der	Dua to (or as a consaquenca ot):			1	
	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, Due to (or as a consequence of):				
68760,	be ex ician i		Sequantially list conditions, if any, leading to immediata causa. Entar Undertyling Cause (Disease or injury				
687	g phys	edical	that initiated events resulting in death) Last Due to (or as a consequenca of):				
Box		by Physician/M	d			1	
	a deal	/sici	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. D	id tobacco usa co	ntributs to th	he cause of death?
P.0	requires that the death cer seen signed by the attendin hould be detached for use	Ph	ANEMIA	-1	□ Yss 2□ No	3 Probal	bly 4 Unknown
Records,	uires t sign	d by		24a. W	es en eutopsy	24b. Were	autopsy findings
00	_ L 0	olete		pe	rformed?	comp of de	abla prior to pietion of cause ath?
Re	The law ate has b page 2 s	Completed		1[Yes 2 No	101	M
Division of Vitai	certificate has rector, page 2	BeC	25. Was case referred to medical axaminar?	eath (Check on	y one)		
of \	Physician: this certific	9	1 Ves 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing		sidenca 6 Oth		
on	ding F h. After funer	tlon	27. Mannar of Death 1 Accident invastigation 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 No	280. Dascrit	e how injury occur	red	
Visi	Atten or deal octor: by the	Certification:	3 Suicide 6 Could not be		(Street end Numb Town, Stata)	per or Rural F	Route Number,
Ö	rs afte	Cert	4 Homicide building, a(c. (Specify)	City or	own, Stata)		
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funer al Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Cartifiar (Check only one) 1. Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date end plac Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the tima, date end plac Check only one)	ca, and due to the curred at the time	ne cause(s) and ma e, data and pieca,	anner as state and due to th	ed. ne cause(s)
	Withir To the comp	Me	29b. Signature and title of certifier 29c. License number	~	29d. Date signe	d (Month, Da	ly, Year)
			1 (yorkheedy) D52228	\$	1/17	2000	
-	9		30. Name and address of barron was completed cause of death (Item 23a) (Type, Print), A OCHUCA 3007 E NORTHORN PK 31. Dete filed (Month, Day, Year) JAN 1 9 2000 Jan 1 9 2000 Jan 1 9 2000	Lwy.	Baltin	roce.	Md.
	[™] Sta Registi		JAN 1 9 2000 /32. Registrar's Signature	/			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 4c. County of Death 10 /Medical 4b. City. Town, or Location of Death 4s Facility Name (If not institu n, give street and r Examiner 0 8. Date of Birth (Month, Day, Year) 9-18-19 If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Ye 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Deys 1 M 200 F Months Hours 2 212-70-655 Md Director Usual Residence of Decede permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental hygiena. Important: if item 27 is marked other than "natural" ... eny injury or other treumatic averages. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Ba Himore Funeral Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 2940 ,5 21216 Street Masher 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cunil Elementary/Secondary (0-12) College (1-4or 5+) ashjer 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) William Wake Hudson sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ho, Md 2,216 Jartin 20b. Place of Disposition (Name of cometery, crematory or other place Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removet from State Dete 20c. Location - City or Town, Stete em butus 4 Donation 5 Other (Specify) Hark 21. Signature of Funeral Service Licensee 22, Neme end Address of Facility 2/2/5 Ho, Hd Wabast 300 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical neumma Examiner Dua to (or as a consequence of): Physician/Medical Examiner ncer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burlel-tran Bud Die to (or as a consequence of) The lew requires that the deeth certificate be exec Box 68760, physician Due to (or es a consequence of): for use as e signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vitai Records, P.O. 3 Probably & Unknown 1 ☐ Yas 2 ☐ No Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 1 Yes Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Placa of Death (Check only one) 1 Yes 8 No 27. Manper of Death Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA this To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigs Division 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, term, street, tectory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of configuration 29c. License number 29d. Date signed (Month, Day, Year) 00 se of death (ttem 23a) (Type, Print) MMMC

DHMH 16 Rev 6/95

State

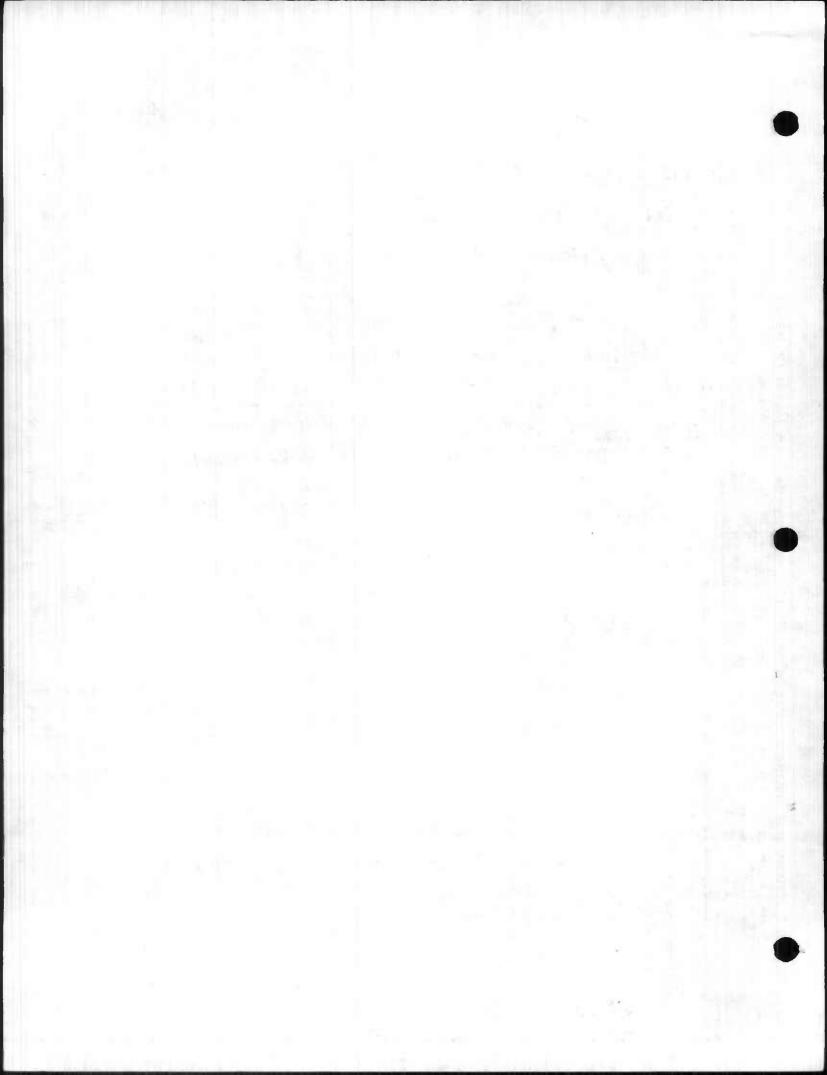
Registrar

31. Data filed (Mor

9

2001

32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \mathbb{U} \mathbb{U} Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Willis 5:38pm Margaret Jan 13,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Josephis 10WSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1□ M 20 F **Funeral** 56 -56-3941 Yrs. May 20, 1943 Director Alabama Usuat Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Balti more Cockeysville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Bridge 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? or Itserve Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 ahould be Illed within 72 hours after ment of Health and Mental Hygieno.
Ant: If Item 27 is marked other than "natural; or its under transmitted event, the Medical Examples in yor other transmitte event, the Medical Examples. 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates: 1□ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Home Homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Velma Miller Hughie Grantam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V-Spouse Queens Bridge (+ Cockeypville, mD 21000 2A Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Jan. 17, 1⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State Sharon Hills Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Dover, DE 2000 21. Signature of Funeral Service Licensee

22. Neme and Address of Fecility

Eyans (hape) of memories

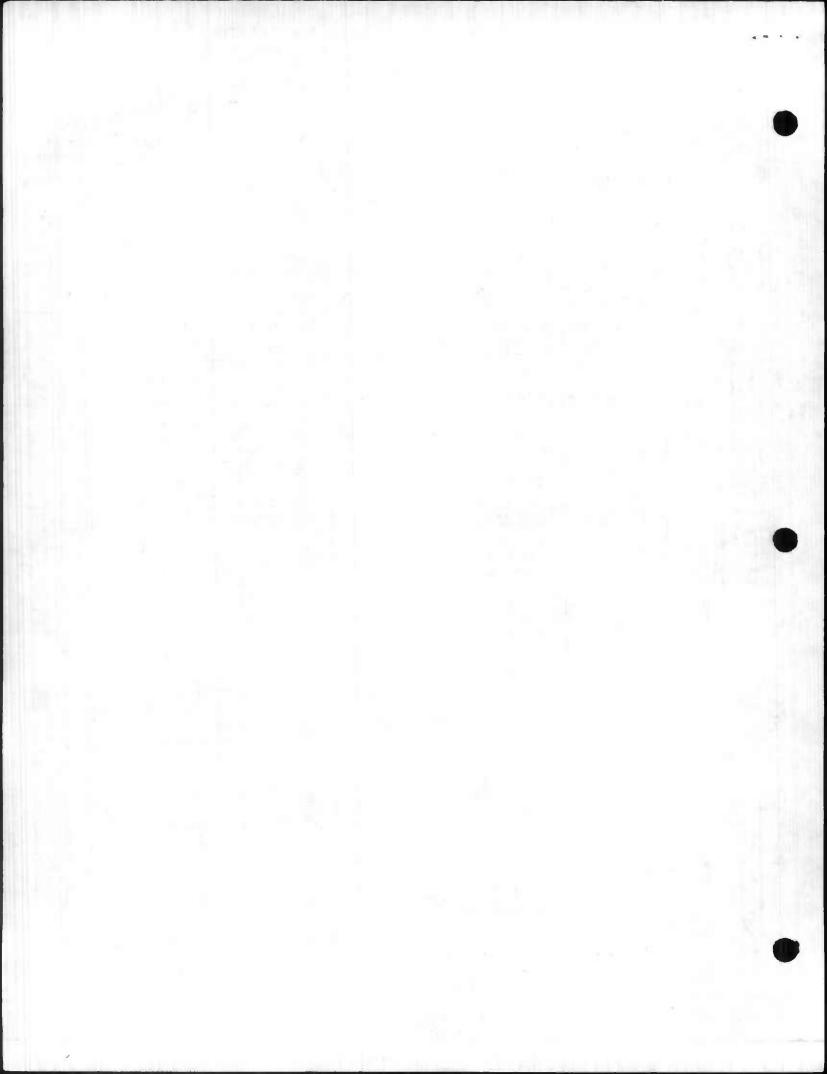
Eyans (hape) of memories

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Obstructive Pulmanory 4 cors Examiner Due to (or as a consequence of): Examiner Attending Physicien: The lew requires that the death certificate be axecuted the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arterios clerate Cardiovascular discesse Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? Dieheter Mellitus type I 24a. Was an autopsy nectormed? 1 Yes 2 No 1 Yes 20 No : After this certifical a funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending To the Hospital or Attending within 24 hours effected asith. To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26637 1/14/2000 W pleted cause of death (Item 23a) (Type, Print) #311 TOWSON MD USCER DR J46 LP418 DARRY MO 7600 31. Date filed (Month, Day, Year) 32. Registrat's Signature ooks JAN 1 2000 9 Registrar **DHMH 16 Rev 6/95**

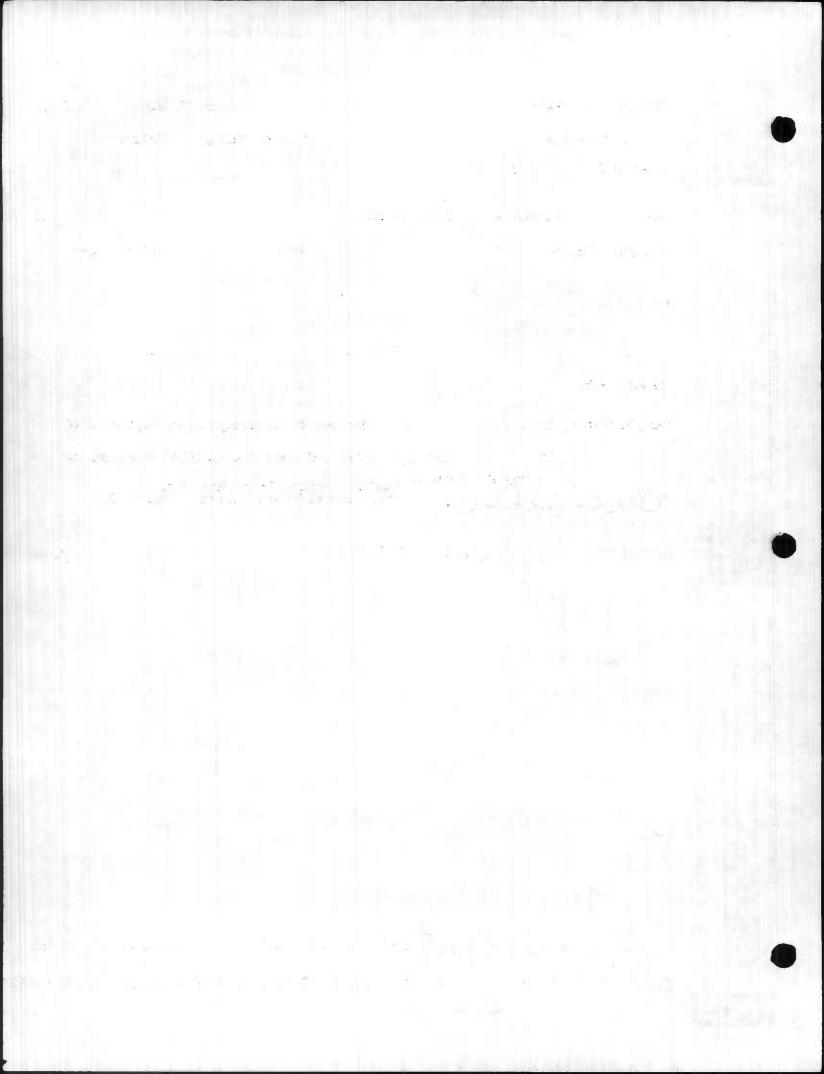
argaret

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** Dorothy L. Walton January 12, 2000 6:33 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9505 Briar Glen Way Montgomery Village Mantgamery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😾 F Months Deys Hours Min 455-14-8155 77 Yrs. July 1, 1922 TX **Director** Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 ☑ No MD Mantgamery Montgomery Village Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9505 Briar Glen Way 20886 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Stetus Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examina DRGs. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2000 Specify: ģ White 36X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Hame 0 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Herman Batts Bessie Hale 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Barry E. Walton / Son 9505 Briar Glen Way Montgomery Village Maryland 20886 20b. Plece of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Payard National Cemetery Jan. 21, 2000 Fort Bayard, NM 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Neme end Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** LUNG CANCER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): SE esn 0 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings eveilable prior to 24e. Wes en autopsy performed? Completed completion of cause of deeth? 1 Yes 2 ₩No 1 TYAS 2 PNO certificate or Attending Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 PAesidenca 8 Other (Specify) Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After 1 Neturel 5 Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide 24 hours Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 the th 29d. Dete signed (Month, Day, Year) 29c. License number 0 D32407 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 9707 MEDICAL CIR DR ROCKVILLE, MA 20850 HAGGERTY JOSEPH MICHAEL MD 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State **JAN 19** Registrar

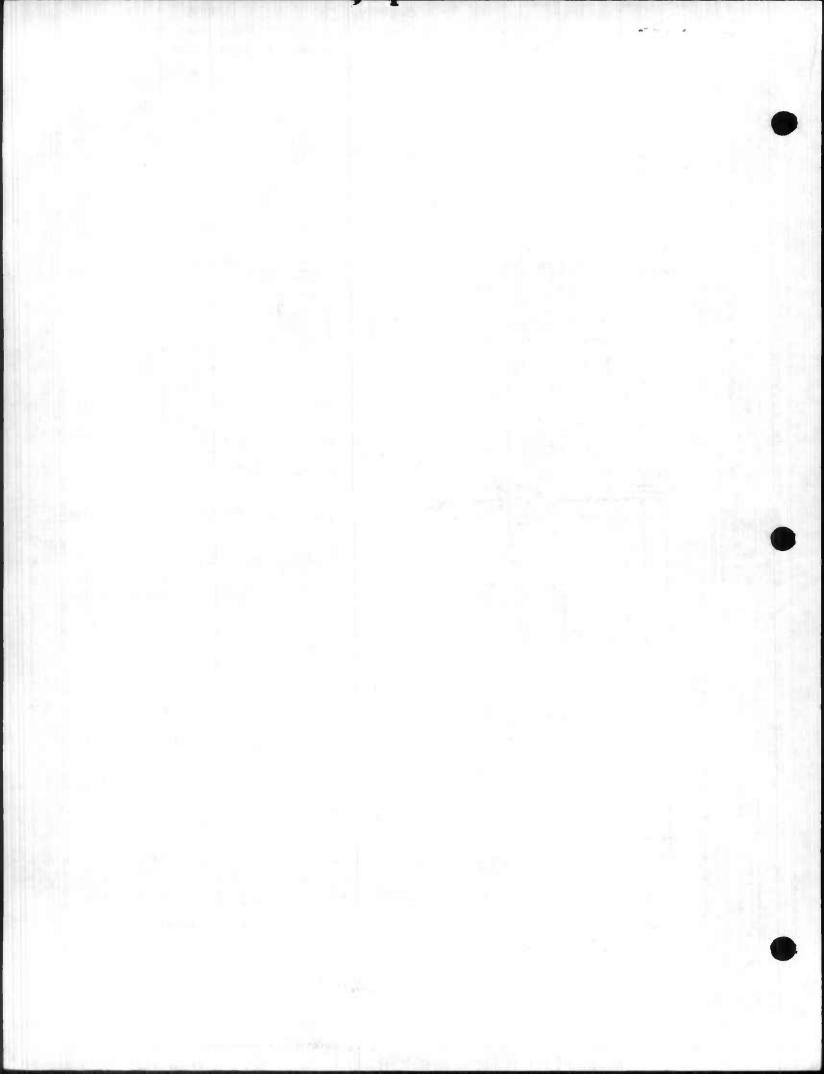
DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2105 Month Day Year Physician 6 lars JANUARY CO 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** medical System Balt: none University of Maryland City Ratimore W Under 1 Year | M Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2□ F 577-42-4519 67 Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 28a-f ahow r than "natural", or home 23e or 28e-f ahor the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 501 N. Dolphin Street Apt.#303 21217 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if flam 27 is marked other than any injury or other traumment. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 10th Grade NA Disabled Disabled 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) John Robinson Mary Williams 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) P.O. Box #67373 Baltimore, Maryland 21215 Whitson 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Voshell Mem.Gardens 01-04-2000 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funerel Service Licensee WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one causa on aech line. On not enter the mode of dying, such as cardiac or respiratory errest, Approximata Intervel Between Onset end Death Physician /Medical Immediate Cause (Final 4RANS disease or condition rasulting in deeth) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown ata nas been signed page 2 should be de Division of Vital Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy Yes 2 No certificata funeral director. 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Mangar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After Naturai 2 Accidant 5 Pending investigation death. 1 Yes 2 No I Director: / filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours a To the Funeral D Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Summers & Gree 22 South 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 2000 9 Registrar

DHMH 16 Rev 6/95



00-0190-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene Cynthia Wilson Certificate of Death AMEND ITEMS: #23 PART I. 27 PER MEO G779 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Cynthia Wilson Roxanne 11, 2000 2:45 P.M. January /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Johns Hopkins Bayview Medical Center Baltimore Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 25, 1960 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 8. Sex **Funeral** Months Days 1 M 200 39 220-66-1437 Maryland Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or itseria 23a or 28a-f show the Medical Examiner must be notified at ¥es 2□No Directo Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 120 W. Jeffrey Street 21225 United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Clerk Manufacturing 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) should be nd Mental James Wilson Ora Johnson 19a. Informent's Neme/Reletionship (Type, Pnint) pus 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1 and 2 s ä Ora Wilson/ Mother 120 W. Jeffrey Street Baltimore, Maryland Health Hem 27 i Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Pages 1 1 ☐ Buriel 2 🗹 Cremetion 3 ☐ Removel from State Chesapeake Crematory Inc. 1/14/2000 Beltsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 21. Signature of Funerel Service Licenses 8717 Green Pastures Drive Baltimore, MD 23. Parf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, mock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SCLERODERMA Examiner Due to (or es e consequence of): Examiner The law requires that the death certificeta be executed use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): and Box 68760. attending physician Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. of Vital Records, by page 2 should be

Completed Be edical Certification: To

23b. Did tobacco use contributs to the cause of ceath? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed? 24b. Were autopsy findings evailable pror to evailable pror to completion of cause of death? 1 Yes 1 Yes 2 No 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 28e. Dete of Injury (Month, Dey Year) 27, Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Ptece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

4 Homicide

30. Name and address of

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Xedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signeture end-title of certifie

O.C.M.E.

29d. Dete signed (Month, Day, Year)

21286

January 12, 2000

State

31. Dalle filed (Mon Year) JAN 1 9 2000 32 Registrer's Signeture

eled cause of deeth (Item 25e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

peed has

certificate

this

After

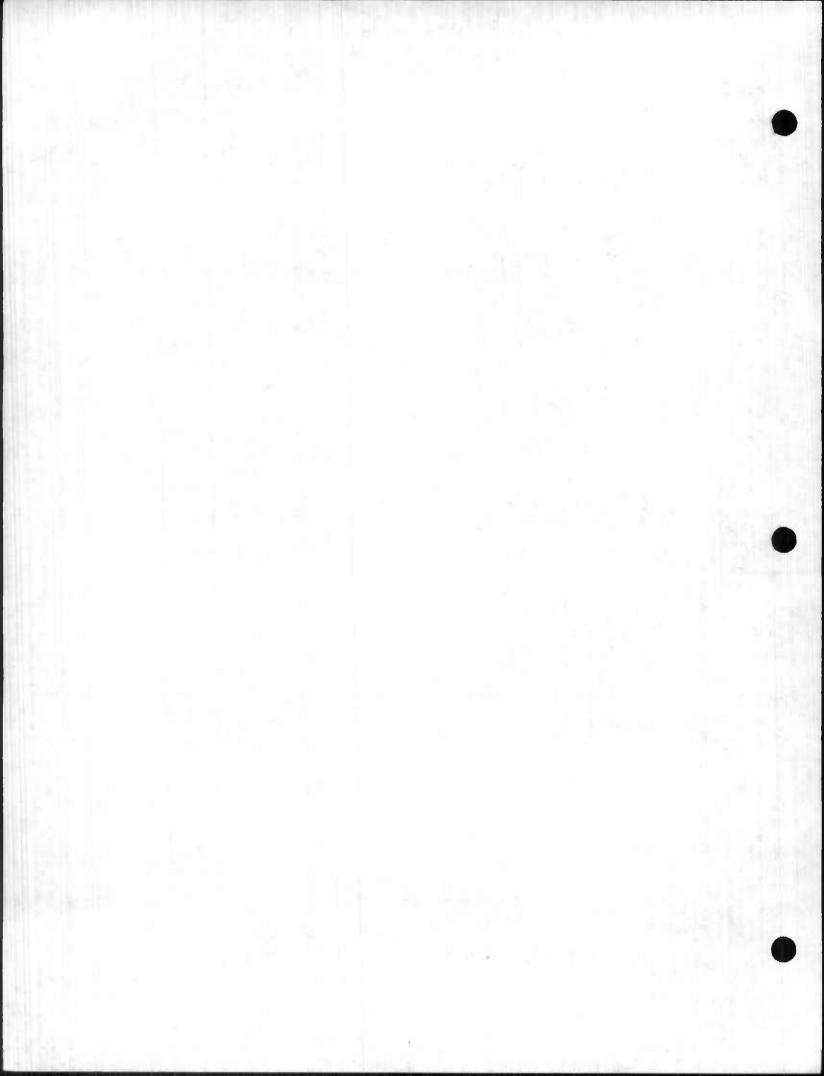
I Director: A

filled in by

l or Attanding Physician: after death.

To the Hospital within 24 hours a To the Funeral C

Division



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** VERONICA YOUNG 1:55 DM 16 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** University Hospital BALTIM HUNDER 1 Year HUNDER 24 Hrs. BALTIMORE CITY GREENE ST BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 21 KF 219-66-6553 Director 41 08 M.D Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yas 2 No Directo Pikesville Baltimore Co. 28e-f 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? res 23a or 8 8019 Valley Manor Road Apt 1A 21117 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 ☐ Yes 2 ☐No Specify: þ 3 ☐ Widowed 4 1 Divorced Year or Dates Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yr+ 12th grade Medical TranscriptionistCrestwood Pediatrics 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: if hem 27 is marked off jury or other traumatic even Be Larry Cheese Sr. Teresa Gerald 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21208 8019 Valley Manor Rd, Unit lA, Pikesville Md Teresa Cheese-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/21/2000 Randallstown, 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md 21215 20a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feiture. List only one cause on even line. Approximate Interval Between Onset and Deeth **Physician** Due to (or as a consequence of): /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner Myocardial or Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Due to (or es a consequence of): US6 85 signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24e. Wes an eutopsy parformed? 24b. Were eutopsy lindings available prior to Completed completion of cause of death? page 2 s 2 No 20 No 1 Yes certificate 25. Was case referred to medical B 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending Netural 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Mccident investigation 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier Medical completely (Check only one) To the Vithin 2 29c. License number 29d. Dele signed (Month, Dey, Year) 29b. Signeture and P13380 impleted cause of death (Item 23a) (Type, Print)

State

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Registrar

JAN 1 9 2000

HELEN

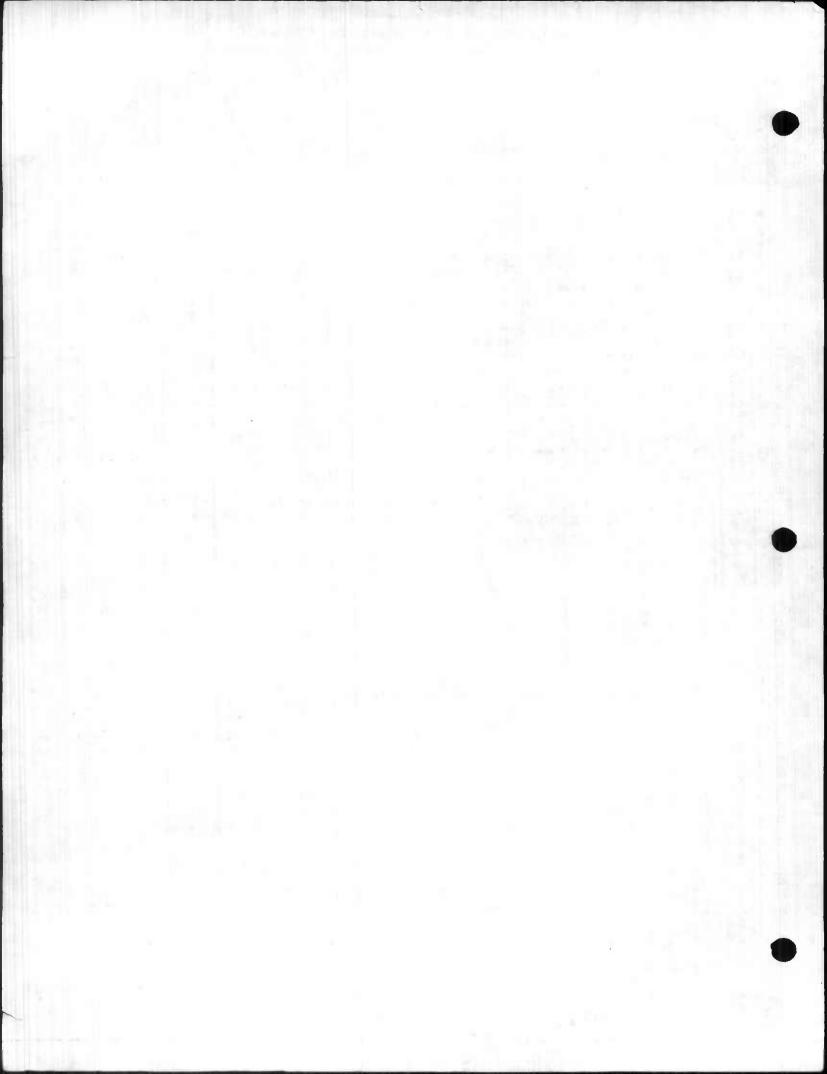
31. Dete liled (Month, Day, Year)

HWAN 6 M. L.

32. Registrar's Signature

GREENE ST. BALTIMORE, MD 2/201 SOUTH

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		ER MD G779 1/19/2000 AH 1. Decedent's Neme (First, Middle, Last)			Certifica	01	Journ	2.	. Date of Dea			3. Time of Death
Physici /Medic		Leona	В.	Zorn				Ja	Month an. 5	, 200	O Year	6:30 au
Examir	ner	4a. Facility Name (If not institution, give	Control of the same				4b. City, Tow			4c. County		
		9016 Hines 8d 5. Social Security Number 6. Sax		ja (In yrs. lest birti	halaul If Lind	er 1 Year	Perry				Inore	
Funeral Director		215-12-8144		0.6	rs. Month		Hours	Min.	Month, Dev	Year) , 1913	County Md	ce (Stete or Forei r) •
ž		Usual Rasidence of Decedent 10a. State 10b. County		10c. City, Town	or Location						104	I. Inside City Limi
Seda	tor	Md. N/A			ltimor	·e					100	1 □XVas 2 □ N
Total I	irec	10e. Street and Number		1	10f. Z	Ip Code			1	0g. Citizen of \	What Country	17
important: If fee ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar issue be notified at once.	Funeral Director	4501 Parkmont		21206				USA				
			Ever in U,S.	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 				y Yas or No- can, atc.)	14. Race - American Indian, Black, Whita, atc.			
	by F	1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 🗆 Yes	2 № No	Specify:			Specify	Whi	ite
	Be Completed by	A						a di cia adata a	16b. Kind of Business/Industry			
	npie	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work iife. DO NOT use retired)							.mg			
	S	/ Yrs。 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Nam							HOME a (First, Middle, Meiden Surneme)			
	To Be								a Doetloff			
	-	19a. Informant's Name/Relationship (Ty							urel Route Number, City or Town, Stete, Zip Code)			
		Leona Martin	daught				s Rd.			11, Md		
		20a. Mathod of Disposition 1 Burial 2 Remark of State 4 Donation 5 Other (Specify)						200	Jane, 20c. Location - City or Town, State Baltimore			
ny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk										
ă ă		Controlly 7110 Sollers Point Rd. 21222										
ician dicai niner		23a. Parv. Enter the disease for complishock, or haart failure. Jist only or timmedlate Ceuse (Final disease or condition resulting in deeth)	beh	. W.							0	pproximete nterval Between Doset and Death
=	ner):						months
-[felts	Examiner	Sequentially list conditions, Due to (or as a consequence of):										moning
s the buriel-trensit	ai E	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	IMPAI	RED MOBILI	TY							
98 179	edicai	resulting in death) Last Due to (or as a consequence of):										
200	M/ue	d	Uste	201010	515						- 2	o yes.
ned for	Physician/M	Part II. Other significant conditions con	tributing to death b	ut not resulting In	the undarlying	cause giv	ven in Part I.		23b. Dld to	bacco use co	ntribute to ti	he cause of dea
Deliberan		Hiatus her	nic						1 🗆 Y	es 2500	3 Probei	bly 4 Unkn
	d by								24a. Was a	n autonsv	24b. Were	autopsy finding
	Completed								perfor		avalle	eble prior to pletion of cause ath?
2	mo								1 🗆 Y	es 2 No	101	
200	Be	25. Was case referred to medical examiner?						of Death (C	Check only or	10)	DAUGUT	nes
500	. To	1 Yes 28 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Sothar (Specify) How									HomE	
	ation	1 Natural 5 Pending 2 Accident Invastigation	28a. Date of Inju (Month, De	y Year) in	jury M	28c. Injur Wor 1 🗌	rk? Yes 2 □ No		3. Describe III	ow injury occur	100	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, etc	ury - At home, fan c. (Specify)	m, street, facto	ory, office		28f	Location (Si City or Town	treet end Numb n, Stete)	er or Rurel F	Route Number,
	edicai C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examination (Check only one)	ician: To the best of er: On the basis of and manner sta	axemination and	deeth occurre /or invastigatio	d at the tir	me, dete end opinion, death	plece, and occurred	due to the cet the time, d	ause(s) end me ate and place,	enner as state and due to th	ed. ne cause(s)
completely filled in by the fu	Me	29b. Signature and title of certified	,		2:	9c. Licens	se number		2	9d. Data signe	d (Month, De	y, Year)
		michi prote mas 041968							1/6/2000			
		30. Name and address of person who co		4.0	Type, Print)	- 1	1 - 0	1	6.11	MD	2112	
		MICHAEL D. A 31. Deta filed (Month, Dey, Year)	MARTIN	MI) ar's Signature	161	LIX	MAIL	a.	07000	1411	010)	7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \lambda \\ \lambda \end{align*} Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3 Time of Death January, Month O JAMES AMMONS, III 10 8:07 AM 00 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veteran's Home St. Marv's Charlotte Hall 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1**∑**M 2□ F 075-18-8141 73 November 19, 1926 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. fnslde City Limits 1 XYes 2 No Charles Maryland Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 United States 61 Mattingly Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 11. Marital Status 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1945-1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 1946 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Employment Cordinator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Henry Ammons, Jr. Sanada Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Henry Ammons, IV/ Son Same as #10 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other piece) 2000 1X Burial 2 ☐ Cremation 3 ☐ Removal from State January 14, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Lightness 22. Name end Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 20640 23a. Pert1. Enter in the fase, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or he is the fitting. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE ORGAN SYSTEM FAILURE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Vonknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed' No

Physician /Medical Examiner

the death certificate be axecuted

68760

Box

P.0.

Records,

of Vital

Division Attending

The law

Department of H Important: If its any injury or ot once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

worde!

must be notified at

ò

Hygiene.

Pages 1 and 2 should be filment of Haalth and Mental Hant: If Item 27 is marked out

other treumetic event.

filed within 72 hours aftar

21215-0020

Maryland

Baltimore,

Director

Funeral

þ

Completed

36

Physician/Medical Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After a contract of the funeral billing in by the fur

by

Be P

Medicai

Examiner

OSTEOMYEZITIS, DEMENTIA, CHRON'S DISEASE, CEREBRO-VASCULAR ACCIDENT, BENIGN PROSTATIC HYPERTROPHY, CORONARY ARTERY DISEASE, CHRONIC OBSTRUCTIVE LUNG DISEASE, BIZ DEFICIENCY LEFT

FOOT ULCER, TRA	NSIENT ISCHEMIC ATTACK,	1 Yes 2 Mo 1 Yes 2 No											
25. Was cese referred to medical	26. Place of Death (Check only one)												
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)											
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	(Month, Dey Year) Injury Work? In	f. Describe how Injury occurred											
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)											

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only

29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Julibor

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature & Signature & Signature & Signature LUKBAN MD FULTON

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** NEDRA GERALDINE JANUARY 7 2000 0149 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND
If Under 24 Hrs. 8 Date ALLEGANY If Under 1 Yaar 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country)
 WEST VIRGINIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1□M 2♥F 63 Yrs Mar. 4, 1936 Director 232-54-4709 Usual Rasidence of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location ahow 10d. toside City Limits WV MINERAL KEYSER 1 Yas 2 No Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 iner must be ROUTE 2, BOX 215-A 26726 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. e filed within 72 hours after de al Hygene. other than "natural", or flerm vent, the Medical Exeminer in Bleck, White, etc. 1 Yes 2 No 1 Never Merried 3 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE à 3 Widowed 4 Divorced Year or Detas. Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First Middle Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 10 JOHN DOWDEN NEDRA STICKLEY 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 DARWIN K. ALT / HUSBAND ROUTE 2, BOX 215-A, KEYSER, WV or other tr 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Steta
4 Donetion 5 Other (Specify) Department of Important: If any injury or page. 1/11/00 EUSEBIA CH. CEMETERY FORT ASHBY, WV 22. Name end Address of Facility
UPCHURCH FUNERAL HOME, INC. 21. Signeture of Funaral Sarvice Licenses P.O.BOX 1260-FORT ASHBY, WV 26719 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) ACUTE MYOCARDIAL INFARCTION 36 hours Examiner Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE unknown sician and burial-transit that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated eventa rasulting in deeth) Last Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): 88 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **SCLERODERMA** signed t Records. ģ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yas 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director Be 25. Wes case referred to medical exeminer? 26. Placa of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ▼ No 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Atter 1 XNeturei 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) á 4 Homicide 6 filled in Hospital 157 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) within 2 \$ 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) JANUARY /O D47507 2000 12 30. Name and edders of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ndes

S.V. BELLARY M.D.

DHMH 16 Rev 6/95

921 SETON DRIVE CUMBERLAND MARYLAND

32. Registrar's Signature

around The I Mh

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month Margare JANUARY 4 2000 12:48 p.m. ordwin 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY BALTIMORE 8. Date of Birth Mar 3, 1934 If Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) 1 M 2 F Months Days Hours 65 216-30-1747 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Elmwood Lane 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: white Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) Ret. Registered Nurse Health Dept 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) (Shives) John R. Stitcher Lucille 19a. Informant's Name/Ralationship (Type, Print) Kimberly A. Lewis Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 6 Elmwood Lane; Cumberland MD 21502 806 daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Rocky Gap Veterans Cem1/10/ Flintstone, MD 21. Signature of Euneral Servica Licens 25 Carpel 1 Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequenca of): ana Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as ranspla Due to (or as a conseque Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona)

Physician /Medical Examine

permit. Page Department of Important: If any Injury or

Physician

· /Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mentel Hygiene.
ant: If Itam 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumetic avent, the Medical Examinar must be notified as

Baitimore, Maryland 21215-0020

ician end burial-transit 88 USB ō page 2 director

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

physician s the burial signed by the a peen has certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral

Examiner Physician/Medical þ Completed Be To Certification:

27. Manner of Daath

4 Homicide 29a, Certifie

1 Natural

2 Accident 3 Sulcide

1□ Yes 2 No

5 Panding Investigation

6 Could not be

1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 ☐ Yes

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, data end plece, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print

32 Registrar's Signature

NA State Registrar

10

edicai

To the I

JANET ME Some

Please Type or Print in Biack Indeiibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician GEORGE** THOMAS BLANCHARD JANUARY 6 2000 3:49PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER A PLATA If Under 24 Hrs. H Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Months 10XM 20 F Yrs Director 214-72-2679 1956 WashingtonDC 10a Stete 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or learns 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MD Charles Port Tobacco Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7990 Terry Drive 20677 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yas 21 No 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 4 3 ☐ Widowed 4 ☐ Divorced Year or Detes: DLAMC HAKD Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Apt. Buildings Maintenance Engineer Appartment of Health and Mental Hygi reportant: If Item 27 is marked other 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be next of Health and Mental William Adams Mary Irene Blanchard Sherron 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7990 Terry Drive Port Tobacco, MD 20677 Sharon Ann Blanchard/Wife Baltimore, 20b. Plece of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete 4 ☐ Donelion 5 ☐ Other (Specify) Metropolitan Crematory1/10/00 Alexandria, VA 21. Signeture of unerel Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646 M00945 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immedieta Cause (Finel ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner DIABETES MALLITUS that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last and Due to (or as a consequence of): physician P.O. Box 68760. Physiclan/Medical the Due to (or es a consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown signed I Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peed certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) edical Certification: To 1√2 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signeture and fitte of certifier 29c. License number Mulia D-50883 MD 7-2000 Tayrem

State Registrar YAHTA

M

31. Date filed (Month,

DHMH 16 Rev 6/95

25500 PT LOOKOUT ROAD LEONARDTOWN MARYLAND 20650

30. Name and address of parson who completed cause of death (ftem 23a) (Type, Print)

32. Registrer's Signeture

TAGOURI

JAN 1 0 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death January 2. Date of Death 1. Decedant's Neme (First, Middle, Last) 3. Tima of Death yce 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death 1724 Prince George's rince Cheverly It Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Deys Hours 1 M 2 N F Yrs. 39 February 10, 1960 Washington, 578-90-5123 Usual Residence of Decedant 10e State 10b. County 10c. City, Town or Location 10d. toslde City Limits 1 ☐ Yes 2 No Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20662 United States 4035 Port Tobacco Road 14. Rece - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Cashier Store 18 Mother's Nama (First, Middle, Maidan Surnama) 17. Father's Name (First, Middla, Last) Raymond Lee Taylor, Sr. Barbara Ann Wilhelm 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Barbara Ann Taylor/Mother Same as #10 20a. Method of Disposition 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) January 13, 2000 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland20640 se, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only ona cause on each line. 23a. Part1. Enter the finder shock, or haari in ra. Approximate Interval Batweer Onset and Deatl Immediate Cause (Final CIRRHUSIS disease or condition resulting in death) Dua to (or as a consequence of): Diabetes MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) COAGULOPATHT Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2☑ No 1 Type 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ₩ Inpatient 2 ER/Outpatlent 3 DOA 28a. Data of injury (Month, Day Yaar) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No investigation 2 Accidant

physician and the bunal-transit The law requires that the deeth certificate be executed P.O. Box 68760 Records, Division of Vital Hospital or Attending Physician: deeth. within 24 hours aft To the Funeral Di complataly filled in

for use as ed by the detached signed by t been si cartificata has t After this cartification after deeth Director: A d in by the f

Physician/Medical py Completed Be Certification: To

Medical

3 ☐ Sulcide

29a. Certifiar

4 Homicide

29b. Signature and title of certifier

Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner maint to notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Heelth and Mentel. Projects. Important: if item 27 is merked other than "natural", or items 23e any injury or other traumatic event, the insertments.

Physician /Medical

Examiner

with the Merylend

State Registrar as Inhabia

6 ☐ Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

D 50686

1/9/2000

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

G S. (HHABRA, SUITE 303 50W EDMONSTON DRIVE, ROCKVILLE

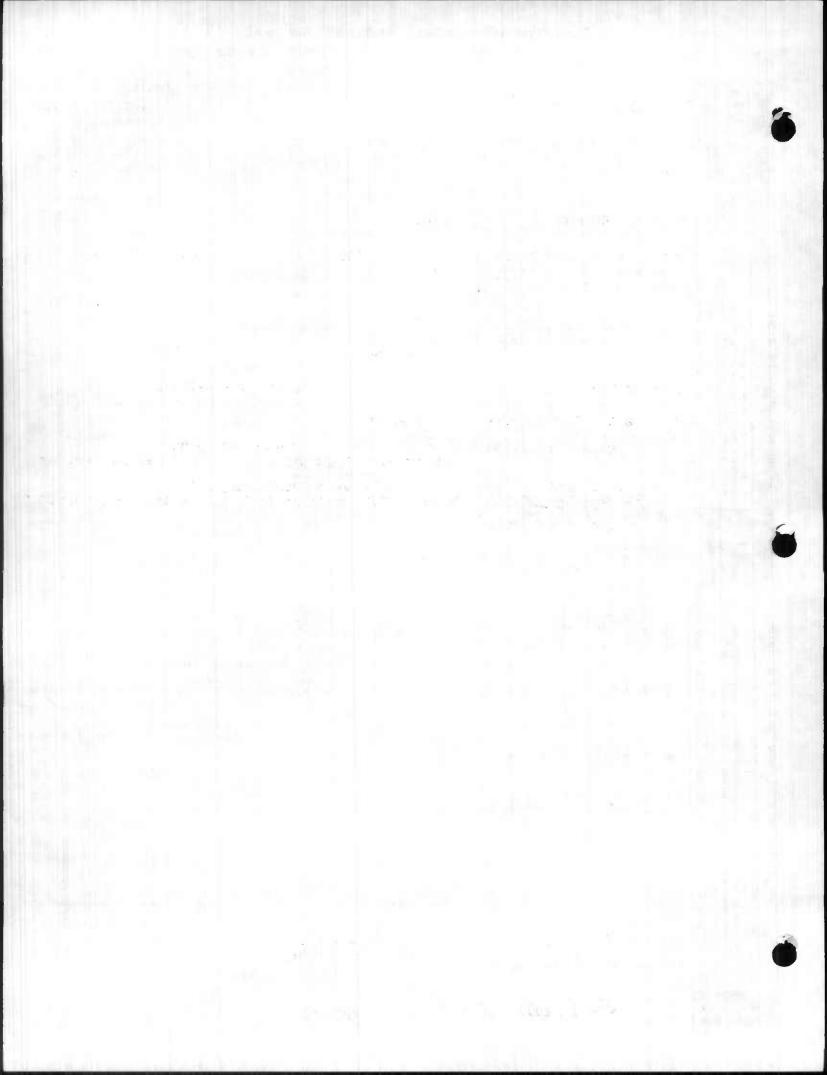
31. Date filed (Month, Bay, Year) 1 2000

32. Registrar's Signature Deper

28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify)

oaks

To the



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** David Allen Bowie 9:30AM January
4b. City, Town, or Location of Deeth 4 2000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) **Examiner** Waldorf 554 Seagrape Court
Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 15 M 2 F Virs Director 212-74-5219 Usuel Residence of Decedent NOV 19 1947 Maryland permit. Peges 1 end 2 should be filled within 72 hours after deeth with the Maryland Department of Heelih end Mentel Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examine must be not a doce. 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 QYes 2 □ No Directo Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 554 Seagrape Court 20602 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 X Never Merried 2 ☐ Merried White 1 ☐ Yes 2 ☐XNo Specify: à 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Disabled None 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Richard N. Bowie Jeannie Bowie Bowie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) Robert W. Bowie (Brother) 3043 "D" October Place Waldorf, MD 20602 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Trinity Memorial Gardens 1-7-00 Waldorf, MD 4 Defetion 5 Other (Specify) 22. Name end Address of Fecility Eberwein Funeral Services M00173 Teller 4433 White Pls la White Pls., MD 20695 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. pproximate Interval Between Onset end Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical years . Colorectal CA Examiner Due to (or es e consequenca of): Examiner ettending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Lesl Due to (or es e consequença of): Physician/Medical Due to (or es e consequence of): by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? been signature 24e. Wes en eutopsy performed? Completed nis certificate hes brill director, page 2 st 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 Inpalient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this funeral 27. Menner of Deeth

1 Naturel

2 Accident 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending death. 1 TYes 2 No Investigation by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 | Homicide 24 hours efter Funeral Dire-letely filled in b ** Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as slated.

2 Wedical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi edical

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

(Check only one)

29b. Signature end title of certifier

Krishan Mathur, MD 31. Dete filed (Month, Day, Year) JAN 10 2000 3500 Old Washington Rd Waldorf MD 20602 32. Registrer's Signeture

29c. License number

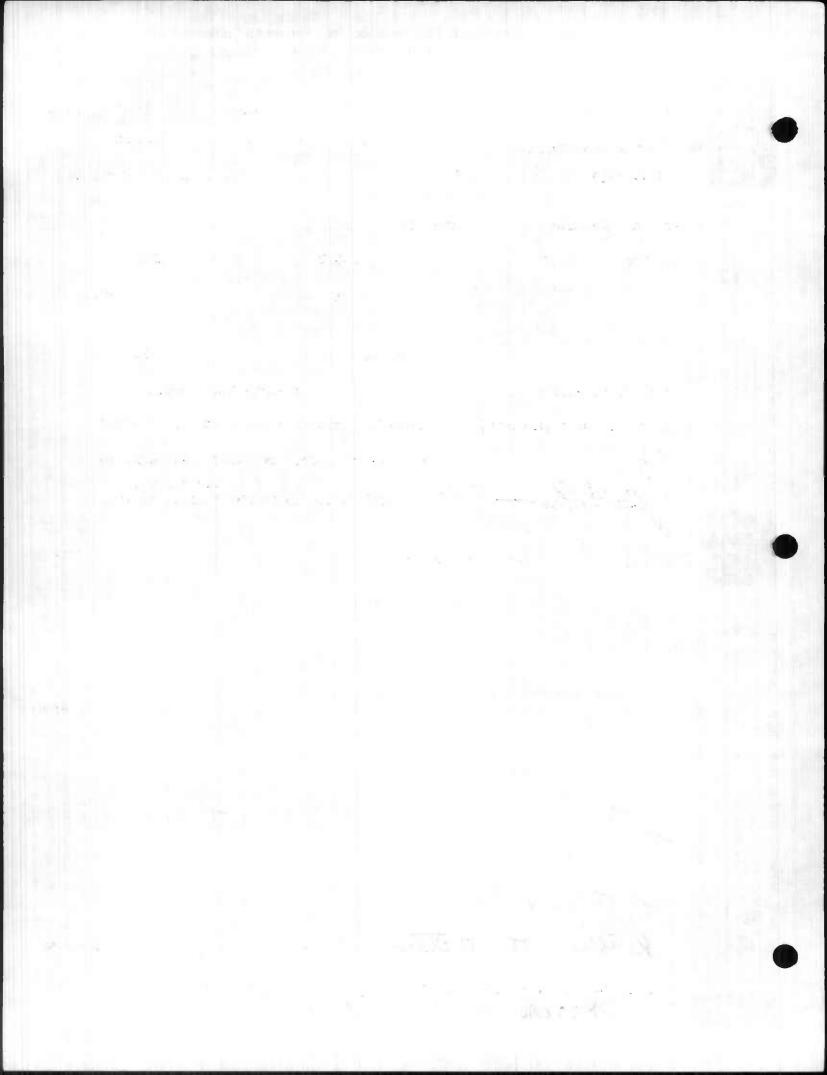
D28352

29d. Dete signed (Month, Dey, Year)

- 2000

Box 68760.

Division of Vital Records,



7. Age (In yrs. last birthday)

Yrs.

OLDTOWN

20b. Placa of Disposition (Name of cemetery, crematory or other place)

10c. City, Town or Locefion

69

12. Wes Decedent Ever in U.S.
Armed Forces?
1 22 Yes 2 D No
If Yes, Give Year or Detest 951-1953

SON

College (1-4or 5+)

Certificate of Death

If Under 1 Yeer

10f. Zip Code

U.S. POSTAL SERVICE

Months

Days

21555

1 ☐ Yes 2 🗓 No Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUNSET CEMETERY JANUARY 10 2000

2. Date of Death

8. Dete of Birth (Month, Day, SEPT 22

18. Mother's Neme (First, Middle, Maiden Surname)

Date

GLADYS STERRY

22. Name and Address of Fecility
MERRITT-ADAMS FUNERAL HOME P.A.

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 FREDERICK STREET CUMBERLAND MARYLAND 21502

404 DECATUR STREET CUMBERLAND MARYLAND

4b. City, Town, or Location of Death

Min

CUMBERLAND

Hours

Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

JANUARY 7

2000

1930

4c. County of Death

ALLEGANY

10g. Citizen of What Country?

U.S.A.

16b. Kind of Business/Industry

20c. Location - City or Town, State

CUMBERLAND MARYLAND

MAIL SERVICE

Raca - American Indian, Biack, White, etc.

Specify: WHITE

3. Time of Death

8:02 AM

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

MARY LAND

-
9
1
Ó
7
64
_
0
α
2
-
SS
T/O
Z
0

cations thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, the cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Approximete Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ne of attending physician end for use es the burief-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury finef Inifiated events resulting In deeth) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to Completed 24a. Was en autopsy peeu completion of cause of deeth? Μel hes The 1 Yes 2 No 1 ☐ Yes 🏚 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Death 28c. injury at Work? 28d. Describe how Injury occurred 28b. Time of After 5 Pending investigation 1 Matural 1 Yes 2 No deeth. 2 Accident within 24 hours efter deet To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es atated. 29a. Certifie edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stetad. \$ 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month, Dey, Year) 16 30. Name and address of person who completed cause of death (item 23a) (Type, Print) hus MEMORIAL HOSPITAL CUMBERLAND MARYLAND 21502 DR ROBERT WELIK State Registrar DHMH 16 Rev 6/95

7 is marked other than "naturel;, or itema 23a or 28a-f sho traumatic event, the Med cal Examiner must be nonfied at permit. Pages 1 end 2 should be filed within 72 hours after death v. Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a and injury or other traumatic event, the Wid call Exercite mass once. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

by

Completed

with the Merylend

1. Decedent's Name (First, Middle, Last)

MEMORIAL HOSPITAL

5. Social Security Number

Usual Residence of Decedent

220-26-9778

10e. Street and Numbe

10a. State

MARYLAND

DON JENE BUCY SR.

4a Facility Name (If not Institution, give street and number)

10b. County

25200 GORMAN ROAD S.E.

1 Never Married 2 Married

3 XWidowed 4 ☐ Divorced

Elementery/Secondery (0-12)

17. Father's Neme (First, Middle, Last)

19a. Informant's Name/Reletionship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

EDGAR L. BUCY

DON J. BUCY JR.

20a. Method of Disposition

ALLEGANY

15. Decedent'a Education (Specify only highest grade completed)

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

or.

1₽M 2□F

SAN : O THE SOURCE OF MALE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** BEALL 1425 JANUARY EDWARD 02 7000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 18 M 2□ F May 21,1926 Director 218-30-3959 73 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22630 Ridge Road 20876 death Funeral United States
14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stalus Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after each of Health and Mertal hygiena.

Int: if item 27 is marked other than "natural", or he in yor other than "natural", or he in yor other than the least. 1 ☐ Never Married 2 Norried 1 Yes 2 No Specify: É 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Inspector County Government 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William Edward Beall Celeste Pearl Watkins 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine H. Beall/ Wife 22630 Ridge Road, Germantown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Upper Seneca Baptist Cem. 1/6/2000 Germantown, Maryland 21. Signeture of Furthral Service Lice 22. Name end Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Causa (Finat disease or condition resulting in death) /Medical Subdural Hematoma Days Examiner Due to (or as a consequence of) Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): signed by the aid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2Ñ No 3 Probably 4 Unknown Bleeding diathesis secondary to coumadin É The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Atrial fibrullation 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axaminer? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 26a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one)

State Registrar

Joseph Ball M.D. 16220 agistrar's Signature 31. Date filed (Month, Day, Year) JAN 0 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIN

29b. Signature and title of certifier

Shady Grove Road Gaithersburg, Maryland 20877

29c. License number

53317

29d. Date signed (Month, Day, Year)

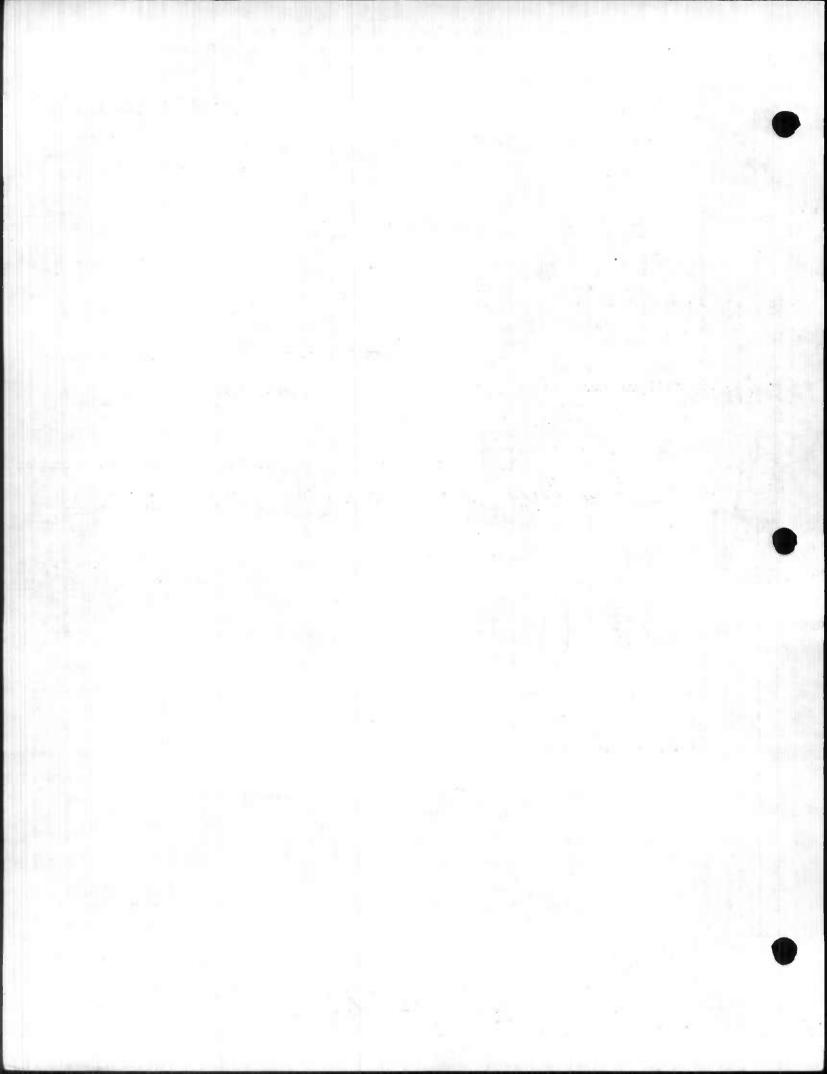
January 3, 2000

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended #8, #18, 1/10/00, CWC, Kent Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3 ennett Bowder Januar 1040 PM 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore City

H Under 24 Hrs. 8. Date of Birth April 69. Birthplace (State or Foreign

(Month, Day, Year)

April 16, 1930 West Virginia Geriatrics C Tohns Hopkins 5. Social Security Number If Under 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Months Days 233-42-2438 69 Director Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director ma 23a or 28a-f r Maryland Queen Anne's Crumpton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21628 USA Mathew Drive Funeral Lot 46 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after di and of Health and Mentell hygiens.

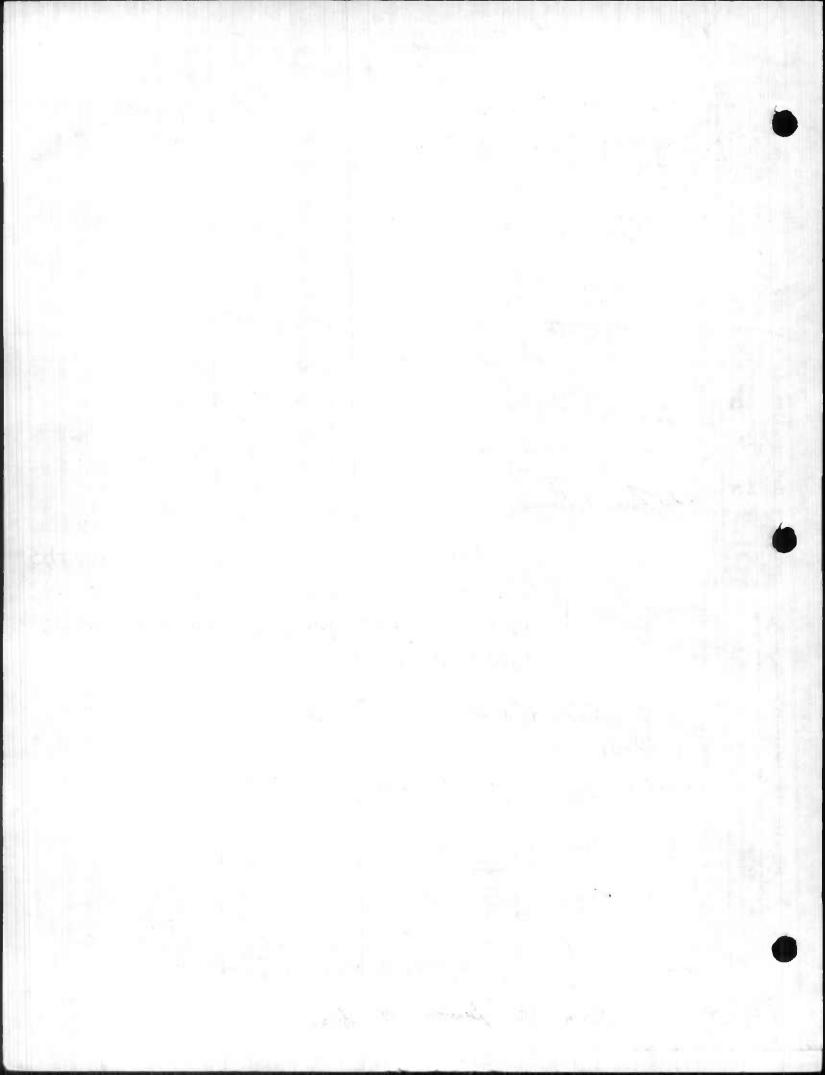
ant: if item 27 is marked other than "caturel", or hem

ury or other traumatic event, the studies is anniver-Black, Whita, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Nerried 21215-0020 1 Yes 2 No Specify Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 8 Machinist Saitlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mark Bowden Macy Raness Foley Bowden 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Anna Bowden/Wife PO Box 261, Crumpton, Maryland 21628 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Crumpton Cemetery 1/8/00 Crumpton, Maryland 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funerat Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximately a respiratory errest, Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Months Examiner o (or as a consequence of): Be Completed by Physician/Medical Examiner dislase The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, obstructive pu Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Dtd tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No lar disease, are the xic 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to ressure ulcers, ventilator completion of cause of death? malnutrition, laryngeal 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai 25. Was case referred to medic examiner? Attending Physicien: 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Junanal 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Neturat 5 Pending investigation e Hospital or Attendir n 24 hours aftar death. e Funeral Director: Al plataly filled in by the fu 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of could pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who a 23 00 مايل 32. Registrar's Signeture 31. Date filed (Month, Day, Year) 21224 State 20**0**0 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yeer **Physician** E, 9:15An Beegle larion 2000 an /Medical 4e Fecility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Gaithers bug Montgomery
If Under 24 Hrs. 8. Dete of Birth/
Month, Dey, Year)

9. Birthplece (State or Foreign
Country)

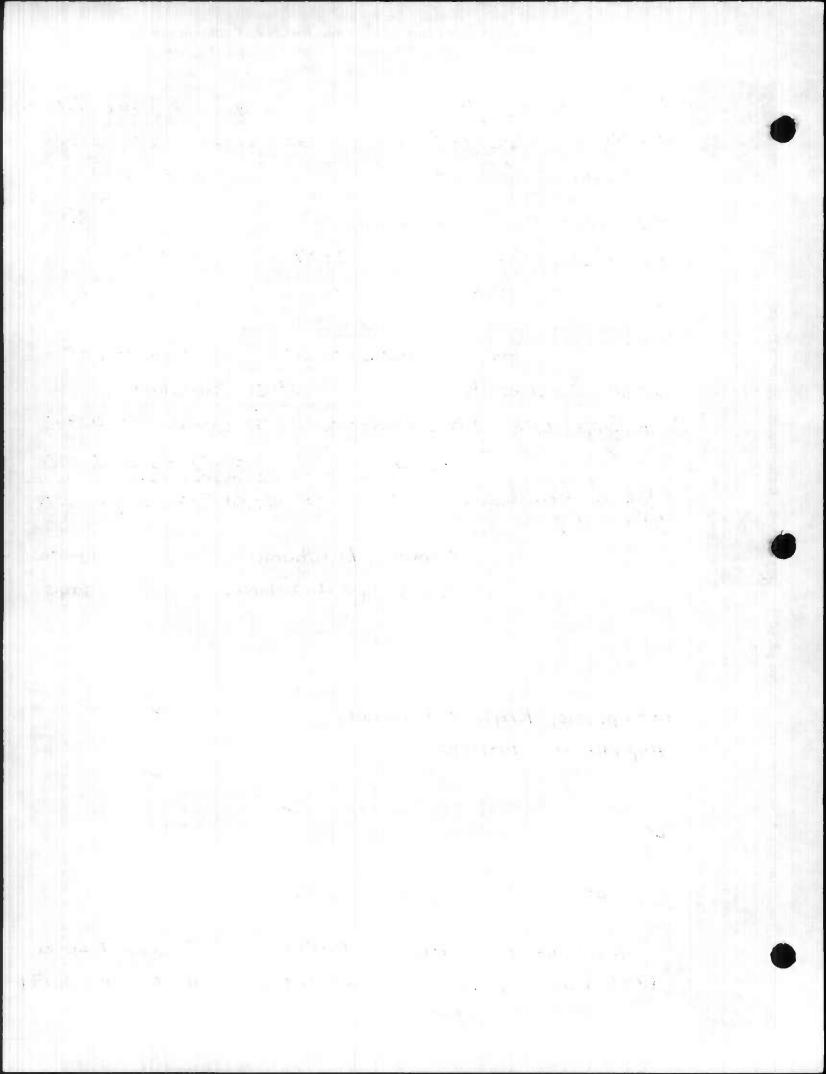
- L ASbury Method & Village, 407 Russell
5. Social Seourity Number 6. Sex 7. Age (In yrs. last birthdey) AVE. If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) **Funeral** Sex 1□M 2XF Deys Months 061-14-3313 NewYork Director 1-08-Usual Residenca of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any Injury or other traumetic event, in Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Gaithersburg Montgomer 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number USA 407 20877 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Meritel Stetus 1 Never Merried 2 Merried 1 Yes 2 No specity: White 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced Yeer or Dates: Completed Decadent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker Homemak 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be dwin Butterworth Slocum Ethel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Dorald Butterworth - Nephew 3365 Highst 20e. Method of Disposition (Nember of cemetery, cremetory or other place) 2365 Highboldge Rd Wilmore, Ky. 40390 Important: If item 27 any Injury or other tr once. 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State Resthaven Frederick MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Zumbrun Funeral 6028 Sykes ville Rd, Elder burg, 4D 21784

Lest chily one cause on each line.

Approximate Physician /Medical Immediete Ceuse (Final Cardiac Arrhythmia Monutes diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner Electrolyte Imbalance days physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown Osteoponsis, Peripheras Neuropathy þ 24b. Were eutopsy findings avelieble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Hypertension, Arthritis is certificate hes director, page 2 1 Yes 2 Tho 1 □ Yes 2 □ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation n 24 hours efter des ne Funeral Director pletely filled in by th 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P. Callaham-tyen 041794 January 2,2000 MD 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) P. Callahan- Lyon mp Russell Ave Gaithersburg mo 20879 911 32. Registrants Signeture 31. Dete filed (Month, Day, Year) State JAN 0 5 2000 > Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Day Bertha Cross 07:05 January 2000 8 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lions Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth Month, Day, Year 1915 Birthplace (State or Foreign Counts) WID 1□M 2□F 220-58-0299 84 Yrs Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City I Imits 1 ☐ Yas 2 ☐ No Mineral Wiley Ford 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 26767 USA P.O. Box 105 12. Was Decadant Evar in U,S Armad Forces? 13. Was Decedant of Hispenic Orlgln? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, atc 1 Yas 2 No If Yas, Giva Yeer or Datas: 1 Navar Married 2 Marriad 1□ Yes 2□√yo Specify: white 3 X Widowed 4 ☐ Divorcad 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Coltaga (1-4or 5+) cook B & O YMCA 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) John Whisner Cora Gordon 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) P.O. Box 2151; Cumberland, MD 21503 Sandra K. Muir 202 Mellogot Disposition 20b. Placa of Disposition (Nama of cametary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Xurial 2 Cramation 3 Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Restlawn Memorial Gard1/10/ LaVale, MD 21. Signature of Funerel Saprice Licenses 22 Scarperii Foruneral Home P.A. Cumberland, Maryland 23a. Part1. Entar the disaasa, or complications that caused the deal shock, or haart failura. List only ona causa on aach line. bo not antar the mode of dying, such as cerdiac or respiratory arrest, Approximete interval Between Onset and Death Immediata Cause (Final disaasa or condition resulting in daath) Jeans orona Due to (or as a consequence of) Dua to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 Unknown 24b. Ware autopsy findings available prior fo completion of causa of deeth? 24a. Wes an autopsy performed? 1 Yas 2 NO 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only one)

Physician /Medical Examiner

Examiner

Physician

/Medicai

Examiner

10a. Steta

Director

Funeral

þ

Completed

Funeral

Director

show

1 end 2 should be filed within 72 hours after death with the Marylai Haalth and Mentel Hygiene.

em 27 is marked other than "natural", or hems 23a or 28a-f show ther traumatic event, the Medical Evaprame must be not the

end 2. ent of Haalth ar. nt: If Item 27 is vor oth

Depertment of Important: If any injury or

Pagas 1

death with the Maryland

Hospital or Attending Physician: The law requires that the death certificate be axecuted 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicien and bunal-transit physiclen the signed by t funeral director,

P.O. Box 68760.

Division of Vital Records,

Physician/Medical by Completed Be Medical Certification: To filled in by the To the Hospital within 24 hours a To the Funeral Completely filled

> 5 MA

State Registrar

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 het 25. Was cesa rafarred to medical axaminer? Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatienf 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Msdicaf Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura and fille of Cartifian

29c. Licansa number 33280

Cumberland

29d. Data signed (Month, Day, Year)

30. Nama and address of parson who complated causa of death (Item 23a) (Type, Print)

M.D. 625 Kent

(Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95

100000 t ye t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 6, LARRY FRANCIS CASPER 2000 9:00 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 9800 BUNKER HILL ROAD WALDORF CHARLES Hours Min. Sept. 29, 1952 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) XXM 2□F Months Days 47 Yrs Maryland 212-62-0362 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Waldorf 1 ☐ Yes 2 No Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9800 Bunker Hill Road 20603 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 Ĭ Divorced 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Union Carpenter 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Bennie Casper, Jr Julia M. Randall 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14001 Livingston Road, Clinton, Maryland 20735 Bennie Casper, Jr./Father 20b. Piace of Disposition (Name of camatery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Cremation 3 Removal from State Huntt Crematory 01-08-200D Waldorf, Maryland 4 Donation , 5 Other (Specify) 22. Name and Address of Facility The Huntt Funeral Home, Inc. MARK G. M00053 BROHAWN P.O. Box 156, Waldorf, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to the Head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents Due to (or as a consequence of): Dua to (or as a consaquence of): rasulting in daath) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes 2No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner that the death certificate be executed

Box 68760

Division of Vital Records,

Hospital or Attending Physician:

efter death.

To the Hospital within 24 hours of To the Funeral C

Physician

· /Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other treumstic event, the Medical Example, must be notified at

the Manylend

with

Examiner ettending physician and for use es the bunel-transit Physician/Medical þ Completed has this certificate Be To funeral Aftert Certification:

25. Was case referred to medical examiner? Yos 2□ No 27. Manner of Death

29b. Signatura and title of certifier

5 Pending investigation 1 Natural 2 Accident 3 Suicide

6 Could not be determined

1-6-2000

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

400

1 ☐ Yes 2 No

Surcide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Waldorf, Maryland

9800 Bunker Hill Rd., Waldorf, Md 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

**X Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Herr

29c. Licensa number

D-50883

29d. Date signed (Month, Day, Year) 1-7-2:00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

11.

2000

TAGOURI, MD, 25500 PT. LOOKOUT ROAD, LEONARDTOWN, MD 20650

State Registrar 32. Registrar's Signature

thet the death certificate be executed P.O. Box 68760, Division of Vital Records. Hospital or Attending Physician:

with the Maryland

Maryland 21215-0020

altimore.

Medicai pletaly within 2 RUS

Registrar

29a. Certifier

(Check only one)

29b. Signature and titletof

this

After

the

Sunii K. Gupta, M.D., 625 Kent Avenue, Sulte 101, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) JAN 1 1 2000

32 Registrar's Signature

and manner steted.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 33280

29d. Date signed (Month, Day, Year)

Jan 11 2000

Leng N.M.N. Cauth

135-14-1508

August Inischeili

South the entitle the Mennal Conten

Frost para

06-Jul-22 Permit indund

MIRODOMA

Jaguery 8 2000 4.45 P.J.A.

Pansylvania Amstend 910/11/192

emp : ¿'nnlot

.A . El 16.253-

Mark

CHAPTER STEEL owner/operator

Carofine Medicalli

Eatity Neubauck Sec daugher (2 ar Ci.) Leve Fros Bird Mary Leve 21552-

ant have faith temetral 15 Jan-00 New Petriefron Longy

Diest Feberal Joins 57 Frost Ave. Frostperp. Att. 21532

send K. Gepta, M.B. 325 Kent Avanue, Soite 101 Camberland, Minyland 21502

and the former of forces

Please Type or Print in Black indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 10, 2000 11:07 PM ROBERT WILSON CROSS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 5, 1937 5. Social Security Number Birthplace (Stete or Foreign Country) MD 7. Age (In yrs. last birthday) Days Months 15 M 2□ F Hours 62 220-34-1984 Vre Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ⊋ ☐ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12307 Addie Lane 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 29 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert Wilson Cross Lila C (Simons) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State. Zip Code) 12307 Addie Lane; Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Lois J. Cross 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gard1/13/ LaVale, MD 21. Signature of Funeral Service License 25 Carpers Fruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsef and Death ACUTE MYSCARPIAL INFARCTION CORONARY ARTERY DISTAST Immediate Cause (Final MINUTOS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

ð

Completed

MD

Funeral

Director

itam 27 is marked other than "natural", or home 23s or 28s-f show other trsumatic svent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any Injury or other traumatic avant

altimore, Maryland 21215-0020

220-34-1984

with the Maryland

death v

Examiner physician and the burial-transit Part fl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f.

Completed Be P

signed by the at d be detached for director. funarai Certification:

Physician/Medical by

peed this death. Director 3 or she To the Hospital o within 24 hours at To the Funeral Di

Division of Vital Records.

COBERT WILSON CROSS

State Registra

Medical

29b. Signature and title of certifier 7/190 ss of 30. Name and MORN

25. Was case referred to medical axaminer?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

31. Date filed Month, Per Year)

erson who completed cause of death (Item 23a) (Type, Print)

DING CUMPSOWAND, MO 32 Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Dey Year)

15093

1ID Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2E No

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29c. Lisense number

28c. fnjury at Work?

1 ☐ Yes 2 ☐ No

2 ER/Outpatienf 3 □ DOA

28h Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

was in the country of the same

W.C. MA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physiclan** Month 1SENBERG 05:30 AM ESTER January 2000 /Medical 4e. Fecility Name (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5. Sociei Security Number HOSPITAL ELLETON CECIL If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 12 M 2□ F If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (Steta or Foreign Country) Months Deys 163-01-0506 Usuel Residence of Decedent 88 Yrs Director PHILADELPHIA PA. MARCH 20,1911 the Maryland 10b. County 10e Stete 10c. City, Town or Location 10d. Inside City Limits **ahow** 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No CECIL Director MD.

10e. Street end Number RISING 10g. Citizen of Whet Country? 1881 FLEGRAPH 2/9/1 UNITED STATES Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ≥ Yes 2 □ No If Yes, Give Yaer or Detes: WW ZZ Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or her any Injury or other traumatic event, the Medical Experiment 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) DOCTOR OBSTETRICIAN MEDICAL 5+ 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Melden Sumema) Be MOSHE EISENBERG 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CODJUS DR- RISING SUN MD. 2/9/1
(Name of Date 20c. Location - City or Town, State KRISTI ANN EISENBERG-DANGER 20a. Method of Disposition 20b. Ple 48 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) JANUARY . A. FERRIS + CO., INC. 6,2000 WEST CHESTER PA. 21. Signeture of Funerel Service Licansee 22. Name end Address of Facility
HICKS Homer Ler FUNDRALS P.A. Donuted S. Hicks

103 W. STOCKTON ST. ELKT

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feiture. List only one cause on each line. 103 W. STOCKTON ST. ELKTON, MD. 21921 **Physician** /Medical Immediate Cause (Finel I neumonia disease or condition resulting in deeth) Examiner Due to (or es e consequence of): res the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest and Box 68760 Physician/Medical Due to (or as a consequenca of): SE ō P.O. Pert il. Other significant conditiona contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 22 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed peen : certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical examiner?
10 Yes 2□ No Be 28. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 28b. Time of Injury 27. Manner of Deeth Medicai Certification: 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No Dec 23, 1995 14'00 M 10

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) F-2/ 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 4 Homicide Calvert Maror, Rising Sun home hursing 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as steted. Certifying Physician: To the best of my knowledge, death occurred at the limb, date end piece, and due to the causa(s) and memory of the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the causa(s) end mennar steted. 29d. Date signed (Month, Day, Year) 29b. Signature and tria of certifier 29c. License number

who completed cause of deeth (Item 23e) (Type, Print)

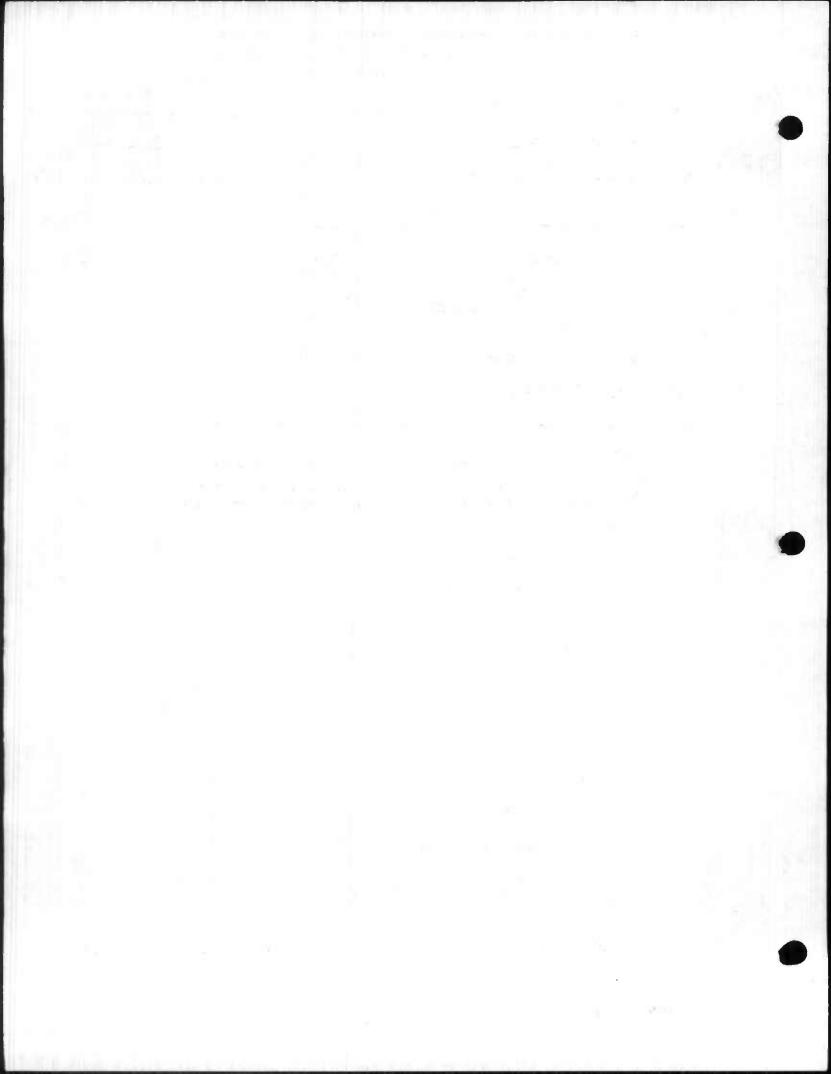
32. Registrar's Signatura

Union Hospital,

January 5, 2000

State Registrar

15



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Deeth 1 Decedent's Name (First Middle Lest) 2. Dete of Deeth Month Yeer LEONA 00 ELKINS 09 01 (Am 4a Fecility Nama (If not institution, give street and number 4b. City. Town, or Location of Deeth 4c. County of Death WAShINGTON ROCKVILLE MD I Hebrew Home 5. Social Security Number 6. Se GREATER montcomeru 9. Birthplace (State or Foreign Country) OH10 6. Sex 7. Aga (In yrs. last birthday) 1□M 200 F 222-24 7826 Usual Residence of Decedent 90 08/31/ 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Rockville 1 Nes 2 No Montgomeny 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Monthose U. S.A. 6105 20852 12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 No ff Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marifal Sfafus 1 Navar Merried 2 Merried Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondery (0-12) Collaga (1-4or 5+) Religious School eacher 12 18. Mother's Name (First, Middle, Meiden Sumema) 17. Father's Name (First, Middle, Last) Lilian Nehem Kin Samuel 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 22015 19e. Informent's Neme/Reletionship (Type, Print) Tess (Street and Number of The Street Or., Bunke, V.A.) Dete 1 200. Location - City or Town, State Bunke, VA Franchon 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition Wilmington 1 Buriel 2 Cremetion 3 Removel from State Jem, ish Community CEM. 4 Donetion 5 Dother (Specify) 21. Signeture of Funeral Service Licenses ould chapa 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feiture. List only to the cause on each line. , Wilm., DE 19809 Approximate Interval Between Onset and Deeth Immediete Ceuse (Finei disaasa or condition resulting in death) Rumonia Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events Due to (or as a consequence of): Due to (or es e consequenca of): resulting in deeth) Lest Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings svailable prior fo 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: Other: 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury af Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

ettending physician and for use es the buriel-transit The law requires that the deeth certificete be executed P.O. Box 68760 the signed by the been page 2 certificate has Physician: After this funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be lifed within 7. Department of Health and Mentel Hygiene. Important: if item 27 is merked other than "ne any injury or other traumatic event, the Mentel once.

Physician /Medical

Examiner

Physician/Medicai Examiner

þ

Completed

Be

0

Certification:

edical

the Merylend

72 hours efter deeth

Baltimore, Maryland 21215-0020

Division of Vital Records, the Hospital or Attending within 24 hours efter death. To the Funeral Director: Al completely lilled in by the fu

> State Registrar

Name end eddress of person

Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Dete signed (Month, Dey, Year)

cause of deeth (Item 23e) (Type, Print)

6121 Montrose Rd Rockville MD

31. Dete filed (Month, Dey. JAN 1 0 2000

4 Homicide

29b. Signeture and title of cartifier

29a. Certifier (Check only one)

32. Registrer's Signeture

Managarana Amerika THE PROPERTY AND A SECRETARY OF LAND. William Baker Brown Tolk Sammer Billerin Below a grade where where and you was not their which will not the The state of the s TAIL MAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** nichelle Yvonne 3, 2000 January 11:55 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 65 Cedar Hill Circle North East Cecil 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2⊠F Months Hours Min. Yrs. 237-41-8106 Director 32 August 6, 1967 Maryland Uaual Residence of Decedent the Menylend 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Itema 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 65 Cedar Hill Circle 21901 United States 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Statua permit. Peges 1 and 2 should be filed within 72 hours effer on Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "natural; or Health any Injury or other traumatic event, the Median Propose. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 □ Never Married 2 N Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In her own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Jonathan Hughes Paula Gray 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Hughes / Father P.O. Box 117, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State January 6, 1999 North East, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) North East Methodist Cemetery 21. Signature of Funeral Service Licen 22. Name end Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 2190 West 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Betw Onset end Death **Physician** Cervica /Medical Immediate Cause (Finet disease or condition resulting in death) anceR Examiner Due to (or as a consequence of): Examine physicien end s the buriei-transit The lew requires that the death certificets be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Division of Vital Records, þ cate has been significant. 24b. Were autopsy lindings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No Attending Physicien: 25. Was case referred to medical axaminer? 8 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month), Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune 5 ☐ Pending 1 ☐ Yes 2 ☐ No N/H investigation MA NIA 2 Accident 6 Could not be 3 ☐ Suicide . Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide MA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. edicai 29a. Certifie 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one)

Registrar **DHMH 16 Rev 6/95**

State

20b. Signature and title of certifier

dress of person who completed cause of death (Item 23a) (Type, Print)

Shortz, mb, Km 600 North Wolf Stree 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year) January 7, 2000

Baltmore, MP 21287

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day RAQUEL PETTERSON FERRO 11:45 00 4b. City, Town, or Location of Death 4c. County of Deeth 4s Facility Neme (If not institution, give street and number) Frederick MD Detour 8212 Sixes Bridge Road 8. Dete of Birth (Month, Day, Year) Jan. 23, 1 If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign Country) Chile 7. Aga (In yrs. last birthday) Hours 1□M 20 F Months Deys 1929 70 227-66-6110 Usuel Residence of Decedent 10c. City. Town or Location 10a. Stete 10b. County 10d. Inside City Limits Frederick Detour 1 Yes 2 No Maryland 10e. Streat and Number 10f. Zip Code 10g. Citizen of Whaf Country? 21757 8212 Sixes Bridge Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 20 No If Yas, Give Yeer or Detes: 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 ☐Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) Coilege (1-4or 5+) Hairdressing Hairstylist 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Herminia Munoz Axel Fisher Petterson 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 8212 Sixes Bridge Road, Detour, Maryland 21757 Elizabeth Ferro (Daughter) 20b. Piace of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State Arlington Nat. Cemetery 1/19/00Arlington, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximete Part1. Enter the disease th. Do not enter the mode of dying, such as cardiac or respiretory errest, Onsef and Death immediate Cause (Final disease or condition resulting in deeth) Ventricular Tady cardia mmediare Dua to (or es a consaquance of) Due to (or es e consequence of). Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia, Hypertension, Parkinsonis, 24b. Were eutopsy tindings availebla prior fo complation of ceuse of deeth? 24e. Wes en autopsy Hypothy pidism, vinary tract infection performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Disease or injury that initieted events ettending physician and I for use as the burial-trans that initieted events resulting in death) Last

Physician

/Medical

Examiner

Funeral

Director

rei', or items 23s or 28s-f show Examiner must be notified at

"naturel". jiene. r than "nature the Medical I

dal Hygie

d 2 should be fi h end Mental H 7 le marked ott

permit. Peges 1 and 2 Department of Health e Important: If Nem 27 le any Injury or other tree

Physician

/Medical

Examiner

The law requires that the deeth certificate be executed

the

been signed by the should be detach

apital or Attanding Physician: Thours after deeth.

nerel Director: After this certificati
y filled in by the funeral director, pr

To the Hospital of within 24 hours a To the Funeral D completely filled in

þ

Completed

Be

Certification: To

edicai

Box 68760.

P.O.

Division of Vital Records.

Directo

by Funeral

Completed

Be

with the Meryland

death

filed within 72 hours after

Maryland 21215-0020

Baltimore,

25. Wes case referred to medical examiner? 1 ▼Yes 2 No		26. Placa of Deeth (Check only one)						
		Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3			Othar: 4 Nursing	Home 5 Pasidence 6 □Other (Specify)		
27. Mannar of Death 1 D Naturel 2 ☐ Accident	5 Pending investigation		28b. Tima of Injury	M 280	tnjury et Work? 1 Yes 2 No	28d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28a. Place of fnjury - At h building, etc. (Speci	noma, farm, streetify)	at, fectory, o	28f. Location (Street and Number or Rurel Route Number City or Town, Stata)			

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and mannar steted

29c. License number

18sules atherene

D0054705

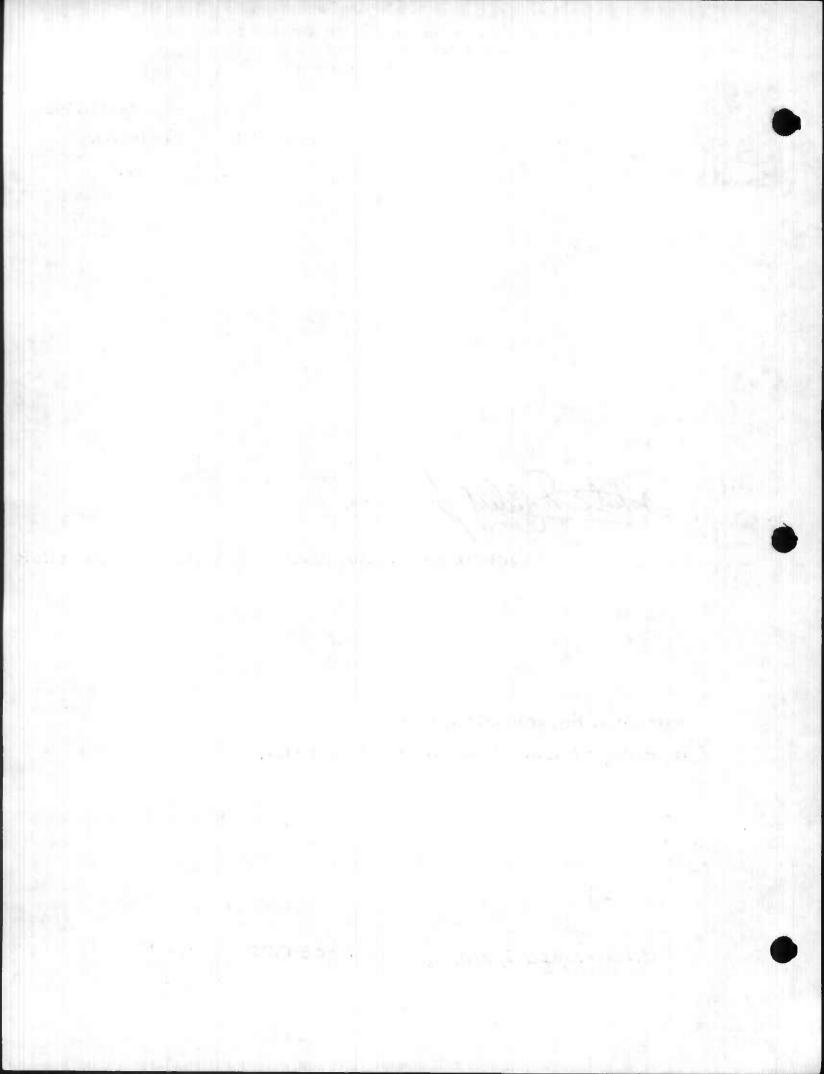
29d. Date signed (Month, Day, Year) 600

30. Name end eddress of person who completed cause of deeth (Itam 23a) (Type, Print)

300 West Ninth Street, Frederick, Maryland 21701 Katherine Buki, MD

State Registrar 31. Date filed (Month, Day, Year) 07 LUUU

32. Regisfrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Paul Harvard Fletcher 6, 2000 11:00 pm /Medical January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1) M 2 F Yrs. Director 216-22-7082 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limita the Marylar the Medical Examiner must be notified at 1 X Yas 2 □ No Director Maryland Allegany **Mount Savage** 23a or 25a-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16026 Foundry Row, N.W. 21545 Funeral Berna 2 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give /
Year or Dates: 1 Never Married 2 Married b 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 8 head custodian education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant! If Item 27 is marked off jury or other traumatic even on and Mental I. 7 is man Be **Conrad Fletcher** Claire Plummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) Debra Suder Daughter Bedford Pennsylva 15522-2454 Bedford Valley Rd. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 □ Cremation 3 □ Removal from State Department in Important: If any injury or and any injury or and and any injury or and and any injury or and any injury or and any injury or and any injury or any injury o 4 ☐ Donation 5 ☐ Other (Specify) **Eckhart Cemetery** 09-Jan-00 Eckhart, Maryland 21. Signature of Funeral Service Licery 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 oun 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, process, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Chronic Bronchitis and Emphysema with acute week Examiner Due to (or as a consequence of): Examine exacerbation use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): put Box 68760. attending physician Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 94 detached signed by 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24a. Was an autopsy performed? page 2 should Completed 24b. Were autopsy tindings peed available prior to completion of cause of death? has 1 🗆 Yes 254 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a Certifier 150. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 2000 D35481 January 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) nes Dr. Mark Sagin, Memorial Hospital, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JAN 1 1 2000

DHMH 16 Ray 6/95

Registrar

Paul Harvard Fletcher

216-22-1082 72

07-Aug-27 Maryland

U.S.A.

Maryland Allegany Mount Savage

16026 Foundry Row, N.W.

21545-

While

head custodian 0.5(10.05/05)

> Claire Plummer Conrad Fletcher

Consister second valle Rd. Bedford Pennisylva 1,522-Debia vider

Eckhart Cemeter 09-Jan-00 Eckhart, Maryland

Purst Funeral Home, 57 Host Ave., Frostburg, MD, 21532

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ELMER ELLSWORTH FLICKINGER 7:40 AM UARWARY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Deys Hours Months 168-26-7329 68 NOVEMBÉR 8,1931 PENNSYLVANIA Director Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits ahova 1 X Yes 2 No Director MARYLAND PRINCE GEORGE'S CLINTON 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8700 JENNIFER COURT 20735 U.S.A. Berne 23a Funerai 11 Morital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 'netural', or M Ass, Give Year or Dates: 1953-1955 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) INVENTORY U. S. Elementary/Secondery (0-12) College (1-4or 5+) 10 **SPECIALIST** MANAGEMENT GOVERNMENT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental BRADY FLICKINGER ESTHER HALL 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RUTH E. FLICKINGER/WIFE important: If Item 27 any Injury or other tr 8700 JENNIFER COURT, CLINTON, MARYLAND 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) THE HUNTT CREMATORY 1/7/2000 WALDORF, MARYLAND 21. Sig 22. Name and Address ot Facility THE HUNTT FUNERAL HOME, P.O. BOX 156, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one ceuse on each line. JAK Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Examine Pheumonit WED The law requires that the death certificate be asseuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Pert tl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be del Records. þ 24b. Wera autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred After or Attending Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medicai completely (Check only one) within 2 å 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print) W. Edmonston DR, #303, ROCKVILLE, MD CHHABRA, MD 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

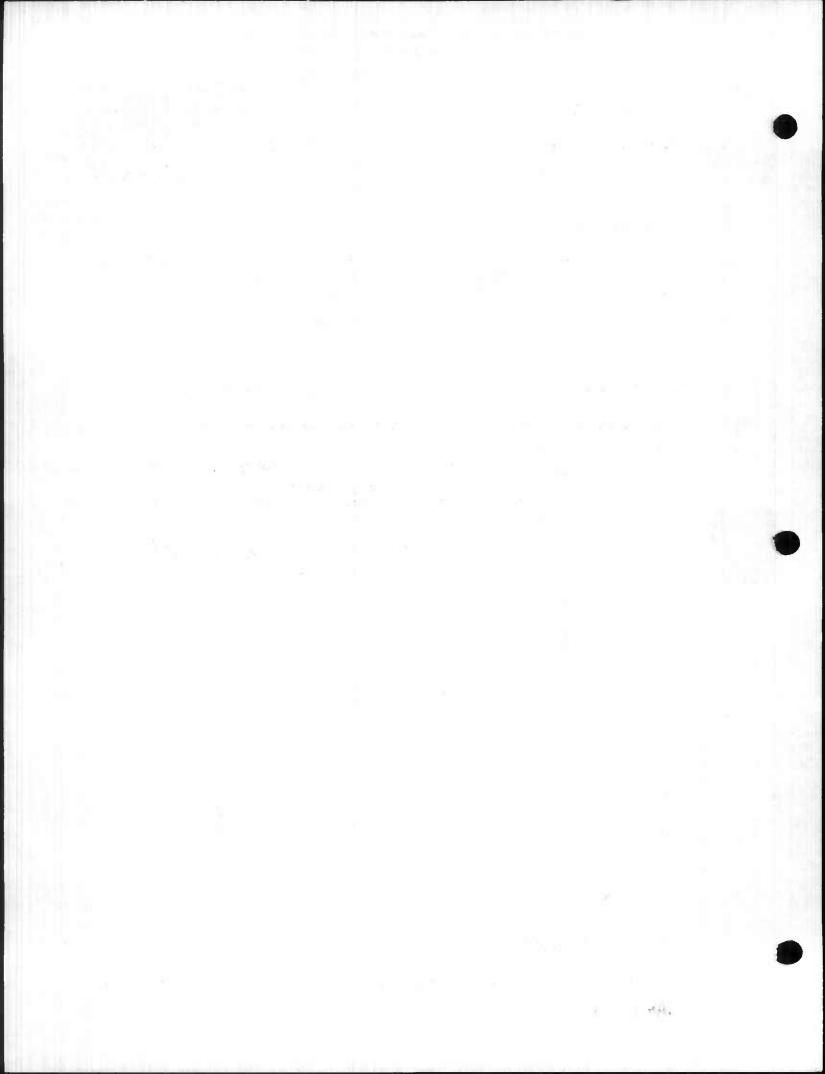
JAN 07 2000

AND BY SOME OF THE PARTY OF THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of Mary				Health and Death	Mental Hy	rgiene Reg. No.	00 (1190	
			1. Decedent's Neme (First, Middle, Las	1)	2. Dete of D	eth		3. Time of Deeth					
Physician /Medical John Edgar Fletche				er				Jan ua	Dey 8	Yeer 2000	11:40 AM		
Examiner 4a. Facility Neme (If not institution, give street and number)					4b. City, Town, or Loc								
1			11 Clearview Aver	nue				North Ea	st	Ceci	1		
	Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birthday) If Un Monti	der 1 Yeer	If Under 24 Hrs	8. Dete of Bi	th		e (State or Foreign	
ii).	Director		N/A Usuel Residence of Decedent	X 201	Yrs.		3		Januar	y 5,2000			
	puel a		10a. Stete 10b. County	100	c. City, Town or I	Location					10d.	Inside City Limits	
	Mary	to	Maryland Cecil North East									1 ☐ Yes 2 No	
	1 the	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co							What Country's	7		
	h with	by Funeral											
	be filed within 72 hours after death with the Marylend stal Hygiene. Id other than "natural", or ferms 23s or 28s-f show event, the Medical Examiner must be notified at		11. Meritei Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13				- 14. Red	e - American i			
0	or h		1 Never Married 2 ☐ Merried	1 ☐ Yes 2 ☑ No	2 No ve 1 □ Yes 2 No						Bleck, White, etc. Specify:		
00	urai',		3 Widowed 4 Divorced	Yeer or Detes:			ороспу.			White	e		
21215-0020	nath rodes	lete	15. Decedent's Edi (Specify only highest grad		(Giv	16a. Decedent's Usual Occupation (Give kind of work done during most of working			orking	16b. Kind of B	usiness/Indust	try	
12	within ane. than	To Be Completed	Elementary/Secondary (0-12) N/A	me.	life. DO NOT use retired)			27/4					
D	al Hygis other I		N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's					18. Mother's Na	N/A Name (First, Middle, Malden Surname)				
lan	Mentai Mentai arked o		Owen Lee Fletcher, Jr.				Emily Cherie Lott						
Maryland	2 should be and Menta is marked raumatic ev						Idress (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	D = - =		Owen L. Fletcher,	Jr. /Fathe				Avenue,					
ore	of He of He item		20e. Method of Disposition	2	ob. Plece of Disp cemetery, cr	position (I	Verne of		Dete	20c. Location -			
Baltimore,	pemit. Pagas 1 en Department of Heal Important: if item 2 any injury or other once.		1 X Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,		Morgan				arv 11 20	Dood Dood	hine 1	Maryland	
alt	Departi Departi Imports any Inju		21. Signeture of Funeral Service Licens			22. Na <i>m</i> e	and Addr	ess of Fecility		VOO WOOD	DAILE, 1	laryranu	
(1)	80 5 9 9		Miles & G.	reru				neral Hom		rth East	Mary1	and 21901	
	Physician /Medical Examiner	er	shock, or heert feilure. List only one cause on each line. Intervel Between Onset end Deeth O							nset end Deeth			
	nsit	Physician/Medical Examiner	b									1	
Ć.	ata be executed hysician and the burial-transit		Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying	Due to (or es e consequence of):						1			
8760,	a be /sicia		that initieted events	C							-		
9	Hic g p		resulting in deeth) Lest	of the second and the second s						4	1		
Box	death certific e attending plad for use es		d							<u> </u>	à		
Э.	0 0 0		Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use co							ntribute to the	e cause of death?		
P.O.	d by the		1 □ Yee 2 💯 No							3 Probabl	ly 4 Unknown		
Ś	The law requires that the ate hes been signed by the page 2 should be detache	by									1		
Record	v require been si should	Completed	24e. Was en eutopsy performed?							evallet	eutopsy findings ble prior to letion of cause		
360	S S S	mpl								of dee	th?		
		To Be							10	Yes 2 No	1□ Ye	es 2 No	
Division of Vital	ysician: The la is certificate he director, page												
o	Phys rai di		1 ☐ Yes 2 A No 27. Menner of Deeth	1 Inpatient 2 ER/Outpetient 3 DOA 4 Nu			4 Li Nuising r	ing Home 5 Residence 8 □Other (Specify) 28d. Describe how injury occurred					
O	ding th. After fune		1 Neturel 5 □ Pending 2 □ Accident Investigation	(Month, Day Yes	r) Injury	M	28c. Inju Wo	rk?]Yes 2 □ No	200.000.00	injury coour			
/ISI	or Attending Physician: after death. Director: After this certific. I in by the funeral director,		3 Sulcide 6 Could not be	At home, ferm, s	e, ferm, street, factory, office		28f. Location (Street and Number or Rural Route Number,			oute Number,			
á	or A after i Direct d in by		4 Homicide determined building, etc. (Specify)						wn, State)				
	To the Heapital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral		29e. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.									d. e cause(s)	
	ithin o the xmple	Mec								d (Month. Dav	, Year)		
	F≯Fŏ		N. Jun						Jan wary 9, 2000				
	a	-	30. Name end eddress of person who co	moniated cause of death	(Item 23e) (Tue-	Print	/			you was	7 17 20		
	2			A NUTLAN		he I	240:10	, 111 Hish st	Suite 7 m	ellto-	M2		
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registrer's S			1,100)111 1177 "	-11 /0/	, EILION,	y		
	Registr	ar	JAN 1 U ZUUU	CHANGE &	J. AO	alla	/						

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** Edward C. Finzel January 6, 2000 15:50 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Linder 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F 212-38-5710 87 Director Maryland 11-May-12 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 □ No Director 288-7 Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Standish Street ð flerns 23a 21532-Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status i Hygiene. other then "natural", or item Bleck, White, etc. 1 DiYes 2 No If Yes, Give Year or Detes: WWII 150 Never Merried 2 Merried "natural", or il edical Examin Baltimore, Maryland 21215-0020 1 ☐ Yes 20 No Specify Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nant of Health and Mental Ira George Finzel **Barabara Anna Finzel** 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Itsm 27 any injury or other tr Grace Finzel Bittner Sister P.O. Box 416 Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 12 Burial 2 ☐ Cremation 3 ☐ Removel from Stete **Finzel Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 10-Jan-00 Finzel, Maryland 21. Signeture of Funeral Service Lice 22. Name and Address of Fecility our Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, phock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Finei disease or condition resulting in death) minutes Cardiac Dysrhythmia Examiner Due to (or as a consequence of): Examiner months Congestive Heart Failure that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): years Radiation for Hodgkin Disease physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of): 212-38-5710 88 years Hypertension signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2/1 No 3 Probably 4 Unknown CACHEXIA, ADRENAL INSUFFICIENCY, FAILURE TO THRIVE Division of Vital Records. þ should l 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law page 2 certificate has Edward Finzel 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 20 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28d. Describe how Injury occurred 26a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 January 7 D0054411 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hes Memorial Hospital Med Bldg 105 500 Memorial Ave Cumberland Calkins Dr. Beverly M. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2000 Registrar

Edward C. Finzel

212-38-5710 Maryland 11-May-12 Frostburg Alleggny Maryland 14 Standish Street 21532-U.S.A. 11 1 elidW - Harring-Teacher 12 ita George Enzel **Barabara Anna Enzel** PULL BOX 416 Maryland 11552 Frostburg 1510 Groce Finzel Billner H-Jan-00 Enzel, Maryland referred (maker

Durst Funeral Home, 57 Frost Ave. Frostburg, MD 21532

may 2 mand 2005/11/14

Physician
/Medical
Examiner

Terrace Susan Fearnow 4e Facility Neme (If not institution, give street and number)

1. Decedant's Name (First, Middla, Last)

January 4b. City, Town, or Location of Death

3. Time of Death Year 0555 2000

Funeral

Washington County Hospital 5. Social Security Number 7. Aga (In yrs. last birthday) 1□ M 2√2 F 214-09-3431

Hagerstown If Under 1 Year | If Under 24 Hrs.

4c. County of Death Washington

Director

natural, or itsms 23a or 25a-f show the Medical Examiner must be notified at

Hygiene. other than

Department of Health and Mental b Important: If Item 27 is marked oil

atla

altimore, Maryland 21215-0020

Directo

Funeral

ğ

Completed

å

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

10b. County

10c. City, Town or Location

Months

8. Data of Birth (Month, Day, Year) Dec. 13,1917

2. Data of Death

Month

 Birthplaca (Stata or Foreign Country) Maryland

Usuel Residence of Decedent

Maryland Washington

Hagerstown

10d. Inside City Limits 1 Yas 2 □ No

10e. Street and Number

10f. Zip Code

Deys

10g. Citizen of What Country?

USA

810 Forest Drive 11 Marital Status

1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yas 2 No

 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 No Specify:

Hours

14. Race - American Indien, Black, White, etc.

White

Yaar or Datas:

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)

21742

16b. Kind of Businass/Industry

Hagerstown, Maryland

Elemantary/Secondery (0-12) 12

College (1-4or 5+)

homemaker

home

Specify:

17. Fathar's Nama (First, Middla, Last)

Annie Mae Smith

Esby Eugene Cronise

19a. Informant's Name/Raietionship (Type, Print) J. Frank Fearnow, Sr.

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 810 Forest Drive Hagerstown, Maryland 21742

18. Mothar's Nama (First, Middle, Meiden Sumame)

20a. Method of Disposition

Burial 2 Cramation 3 Ramoval from Stata
Conation 5 Other (Specify)

20b. Place of Disposition (Nema of cematary, crematory or other place)

Rest Haven Cemetery 1/6/00

Deta 20c. Location - City or Town, Stata

21. Signatura of Funagel Service Licerane

22. Nama and Address of Facility Gerald N. Minnich

305 N. Potomac Street

23a. Part1. Enter the disease, or complications that caused the death. Do not after the mode of dying, such as cardiac or respiratory arrest. Mary Land 21740 shock, or heart failure. List only one cause on each line.

· HypoxiA Dua to (or as a consequence of):

Husband

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONI

FUM TORACCO US WN Dua to (or as a consequence of)

Physician /Medical Examiner

sician and bunal-transit

physician s the buna

signed by the a

page 2 s

this funeral

After

24 hours after death.

within 24 hor To the Fune completely fi

or Attending

Hospital

94

Fearnow, Perrace

Records.

Division of Vital

Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Immediata Causa (Finel diseesa or condition rasulting in death)

23b. Did tobacco use contribute to the cause of death?

1 1 as 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

To JDS Heroskown, NO

24b. Wara autopsy findings available prior to completion of cause of death?

Interval Between Onset and Death

1 Yas No 26. Place of Death (Check only one)

1 ☐ Yas 2 ☐ No

25. Was casa raferred to medical axaminar? 1□ Yas 2 No

Hospital: 1 (1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 5 Pending investigation

Piece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28b. Tima of 28c. Injury st Work?

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

27. Mannar of Death

1 Matural

2 Accident

3 ☐ Suicide

4 Homicida

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examination on the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and titla of contifu

6 Could not be datarmined

29c. License number

29d. Date signed (Month, Day, Year) 00

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Medical

BASAN 31. Date filed (Month, Day, Year)

JAN 0 6 2000

32. Régistrer's Signatura

COMONS

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Data of Death Day Helen Fortney 2, 2000 4c. County of Death 4b. City, Town, or Location of Death 8:25 PM 4a Facility Nama (If not institution, giva street and number) Clearview Nursing Home Washington Co. Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) 1□ M 3/□ F Days Yrs. 76 427-26-2290 December 17, 1923 Mississippi Usual Residence of Deceden 10a Stata 10c. City. Town or Location 10d. Inside City Limits 1XXes 2 □ No Franklin Co. Waynesboro PA. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17268 USA 30 W. 6th Steet 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American indian. Black, White, atc. 1 Yes YNO If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yas 2√ No Specify: Specify: White 3 ☐ Widowed XX Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Educetion (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) Homemaker Housewife 7th 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middla, Last) Fannie Mae Lapkin Mapp Olin 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Rt. 1, Box 163, Falling Waters, W.VA. Lois Decker (Daughter) 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 6, 2000 Quincy, Pa. Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M - 00849Lochstampfor Funeral Home, Inc. 48 S. Church STreet, Waynesboro, Lochstampfor 23a. Part1. Enter the disease, or complications that ceused the reath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1726 Boximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Bronchopneumonia l week Due to (or as a consequence of): Amyotrophic Lateral Sclerosis 2 months Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 X Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rsi', or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 end 2 should be filled within 72 hours efter death 1 Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Examiner, must, once.

Director

Funera

by

Completed

Be

with the Meryland

attending physician and for use as the bunel-trensit signed by the a been si 19 2 si irector, page or Attending Physician: efter deeth. this funeral After t

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai ģ Completed 8 2 Certification:

edical

29a. Certifier

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dehydration 25. Was casa raferred to medicel Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🕽 ☐ No 28b. Time of Injury 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 5 Pending Investigation 1X Natural 2 Accident 6 Could not be detarmined 3 ☐ Suicide 4 | Homicide

1 ☐ Yes 2 ☑ No

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only ona) Other: 41 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Describe how Injury occurred 28c. injury at Work?

1 ☐ Yes 2 ☐ No 28f. Location (Streat and Number or Rural Route Number, City or Town, State)

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licensa number

din

January 3, 2000 D07857

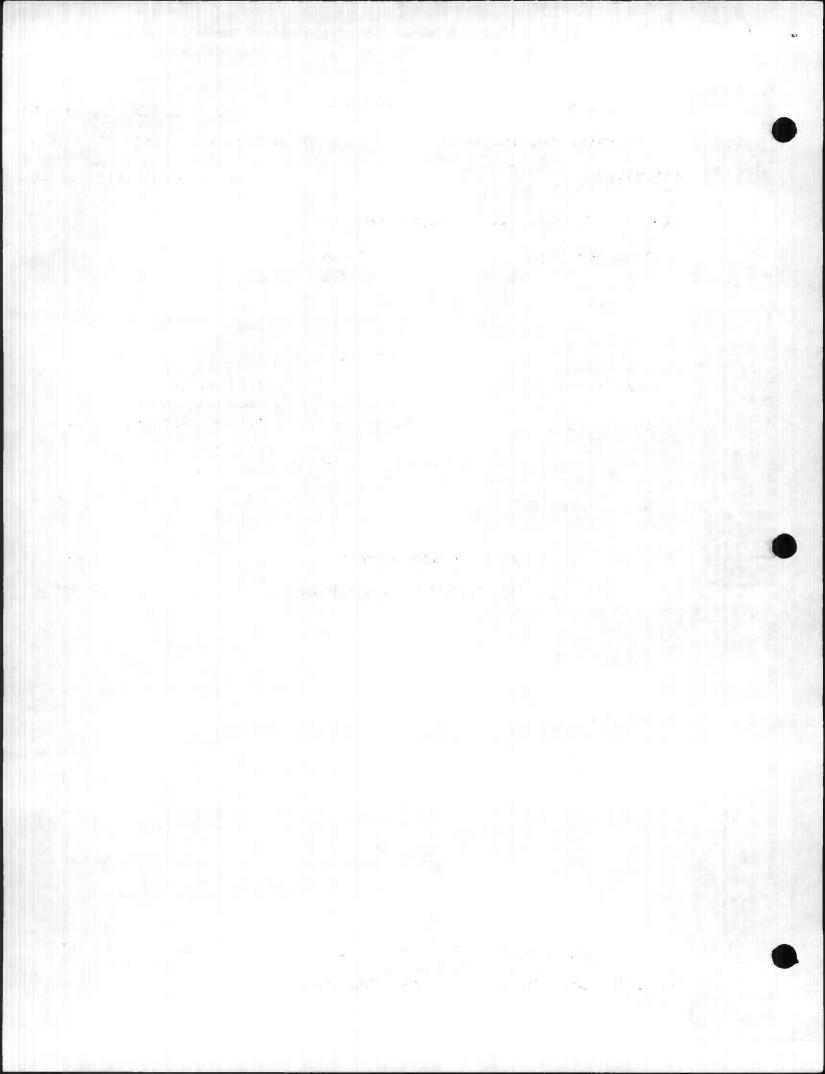
d ceuse of death (Item 23a) (Type, Print) 30. Nama and addrass of person who complete

Dr. E. B. Moody, 1190 Mt. Aetna Road, Hagerstown, MD 21740

State Registrar 31. Data filad (Month, Day, Year) 32. Registrar's Signature JAN 0 5 2000

Reperson

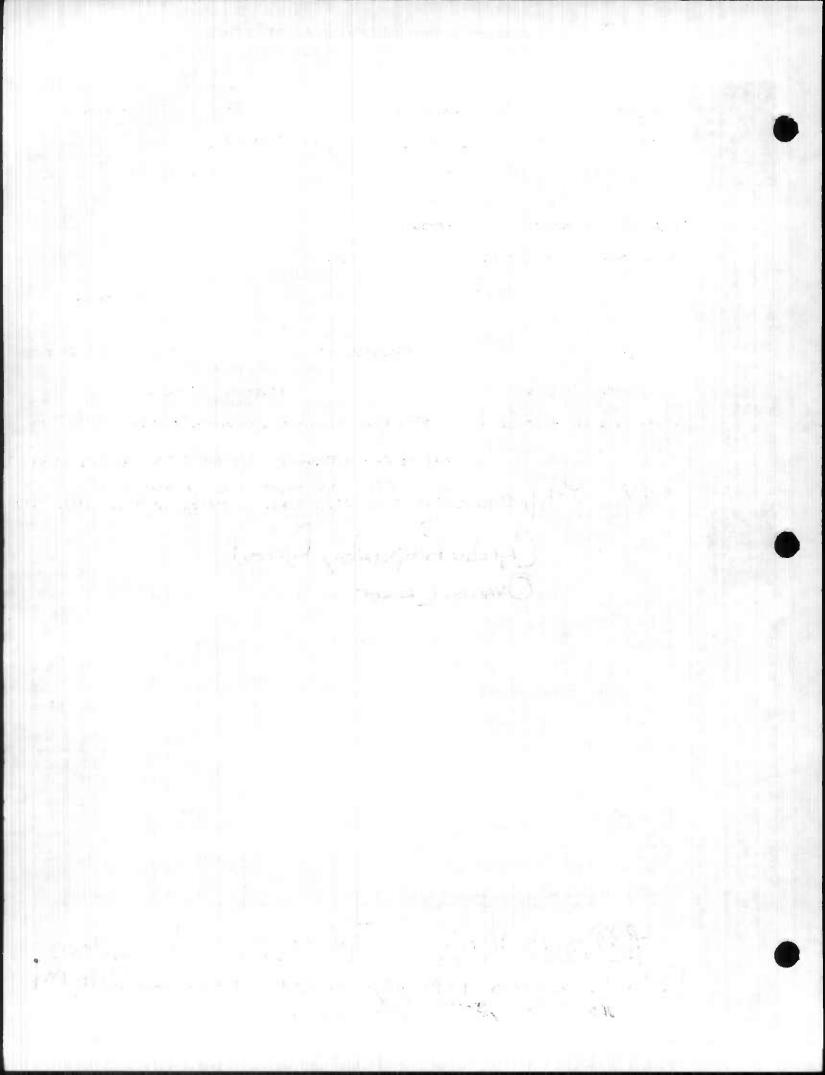
within 24 hours effer deeth To the Funeral Director: A completely filled in by the f



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** PFIGHY 00:40 HELLER' JAN 05 2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Desth Examiner BALTIMORE BALTIMORE MEDICAL MERLY ENTER If Under 1 Yeer | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 10 M 250F Yrs Director 215-66-9779 16 ASY MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinet must be notified at with the Meryler 1 Yes 2000 Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18853 Bent Willow Circle 20874 Funeral U.S.A. death 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. other then "netural", or ite 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Receptionest 12 Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi end Mental H is marked ot James Fellers Florence Fincham 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: If item 27 is m any Injury or other traum Denise L. Parra - Daughter 5422 Weirwood Avenue, Orlando, Florida 32810 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ■ Buriei 2 Cremetion 3 Removei from Stete Gate of Heaven Cemetery 1/07/00 Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117
Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Approximate Intervel Between Onset and Deeth Physician Immediate Cause (Final diseese or condition resulting In deeth) /Medical STATIC Examiner Due to (or as a consequence of): Examiner AU DE Ancer certificate be executed physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) 88 9SF P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the the yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed certificate has 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No P 1 Unpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) uneral 28b. Time of 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 1) Netural Attending 5 Pending Investigation death. 1 Tyes 2 No 2 Accident To the Hospital or Attention Within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Sulcide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steled.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end memper stated. 29a. Certifier (Check only one) 29b. Signati 29d. Date signed (Month, Day, Year)

23a) (Type, Print)



State Registrar Jennes Jewe Mo 31. Dete filed (Month, Day, Year) 32. Registrer Signature

Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

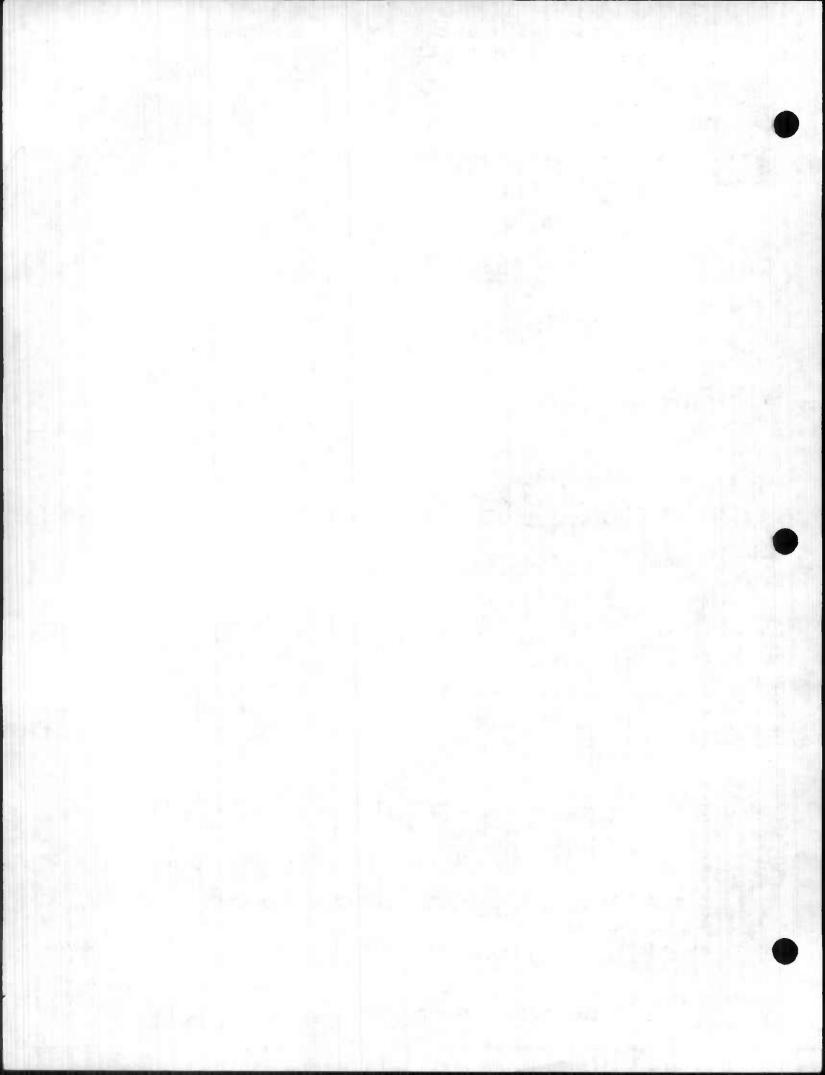
Muter

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

January 03, 2000

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death JANUARY 07, 2000 **Physician** 0600 TOM JOHN GARDNER /Medical 4c. County of Death 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES BRANDYWINE 14110 BADEN WESTWOOD ROAD If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Days M 20 F 218-24-3073 73 Director JANUARY 23, 1926 MARYLAND Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits notified at 1 Yes 2 No Directo MARYLAND PRINCE GEORGE'S BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Medical Examiner must be 14110 BADEN WESTWOOD ROAD 20613 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 (A)Yes 2 □ No H)Yes, Give Year or Detes: 1944 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LIVESTOCK TRADER LIVESTOCK other 17. Father's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Heelth and Mental Hant: if item 27 is marked oth jury or other traumatic aven Be MARTIN E. GARDNER IDA GRACE BROWN 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 14110 BADEN WESTWOOD ROAD, BRANDYWINE, MARYLAND 20613

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date 20c. Location - City cremetory or other place) ROSE MARIE GARDNER/WIFE 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or MARYLAND VETERANS CEMETERY1/11/2000 CHELTENHAM, MARYLAND 5 Other (Specify) 4 Donation 21. Signetare of Funeral Service Company 22. Name end Address of Fecility THE HUNTT FUNERAL HOME, INC., POST OFF:

BOX 153, WALDORF, MARYLAND 20604-0156

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. POST OFFICE Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a ARTERIOSCURPOTIC CARDIOVASCULAR disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest and Due to (or as a consequenca of): physician a Physician/Medical Due to (or as a consequenca of) 98 USe signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has 1 Tes 2 No 1 Yes 2 No certificate Hospital or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 this funeral 27. Manner of Death Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affer 1 Neturel Accident 5 Pending efter death. 2 🗆 No 1 Yes investigation 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homlcide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner is 1.1. 29a. Certifier Medical To the To the I 29c. License number 29d. Date signed (Month, Dev. Yeer) 29b. Signature a

ORIVE, CHEVERLY, MARYBAND 20785

State Registrar GOLL

2000

32. Registrar's Signeture

31. Dete filed (Month

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O.

11.1

South of Charles and a second

en from a Military rate in the co

the Wild of Land of Black

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Day Year Month **Physician** 7:45 PM ROSARIO GRASSO 0 01 ANTHONY 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number Examiner Baltimore
If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) MERCY MEDICAL CENTER 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) **Funeral** 1**10** M 2□ F Months Days 45 Yrs. Director 219-62-2210 11/16/1954 Baltimore, Md Usual Rasidance of Decedant the Maryland 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location Eshould be filed within 72 hours after death with the Marylan hand Mentel Hygiene. Te merked other than "natural", or items 23a or 28a-f show numatic event, me Medical Exam net mast be noulised. 1 XYas 2 □ No Directo Baltimore MD. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21224 U.S.A. 1120 South Potomac Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U.S. Amed Forcas? 1973 1 Navar Marriad 2 Married Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 Divorced Caucasian 1974 Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 2 Engineer Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Phillip Grasso Alice Jean Fish Anthony permit. Pages 1 and 2 sh Department of Health and Important: if them 27 is me any injury or 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Carol L. Grasso /Wife same as #10 a,b,c,e,f Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Timonium, Maryland Dulaney Valley Cem. 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility E.G. Kurtz & Son Funeral Home, P.A. Donjamin Muth Jarrettsville, Maryland n 23a. Part 1. Ente 11 disaasa, or complications that shock, or half failura. List only ona causa or may tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Between Onsat and Death **Physician** /Medical Immadlata Causa (Final CARDIOMYOPATHY disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of): Examiner APNEA SLEEP physician and the burial-transit be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760, MORBID OBESITY Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peed 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Was cesa rafarred to medical Be 26. Place of Death (Check only ona) axaminar' Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas X No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Mapnar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: Affer Natural 5 Panding 1 Tas 2 No death. invastigation 2 Accident after death Director: 6 Could not be datamined 3 Suicida To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number

State Registrar

BARBARA ALEXANDER 31. Data filad (Month, Day, Yaar) JAN 0 5 2622

exandle

29b. Signatura and titla of certifiar

32. Ragistar's Signatura

MD

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

PLACE Baltimore MO 21202 301 ST PAUL'S

D50016

AND THE RESERVE OF THE PARTY OF 1 (1 _ _ _ T FEET DATECTOR CTEUM of IS The Boltz Markett and the state BUREAU CONTRACTOR TO THE CONTRACTOR OF THE CONTRACTOR ALC , I will a little of the Eld Schuld

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month Carrie Rebecca Garv 2000 January 1010 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death The Kent and Queen Anne's Hospital, Inc. 's Hospital, IIIC. 7. Aga (In yrs. last birthday) 8. Pata of Birth (Month, Day, Yaar) August 23, 1916 Chestertown 5. Social Security Number Birthplace (Stata or Foraign Country) 1□M 2IXF 220-28-4618 Maryland Usual Rasidance of Decadant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Kent. Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 9181 American Legion Drive 21620 USA 12. Was Dacedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Specity: White 3 X Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collega (1-4or 5+) Sales Clerk Fabric 17, Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Unknown Lulu Greenwood 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Arthur Gary/Son 9944 Farilee Road, Chestertown, Maryland 21620 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Department | 2 □ Cramation | 3 □ Ramoval from State | 4 □ Donation | 5 □ Other (Specify) Chester Cemetery 1/8/00 Chestertown 21. Signature, of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errast, Approximate shock, or heart failure. List only one cause on each lina. Immediata Causa (Final color concin disaasa or condition rasulting in daath) 3705 Due to (or as a consequanca of): Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to madical examiner? 28. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 28 No Impatiant 2 ER/Outpatient 3 DOA 27. Magnar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation Natural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 4 Homicida

that the deeth certificate be executed and physician a s the burial-Box 68760. 0 Division of Vital Records, P.O. the signed by t peed cartificate To the Hospital or Attending Physician: within 24 hours after death. this After Director: within 24 hours after To the Funerei Dir complately filled in

Physician/Medical by Completed Be Certification: To

Medical

6

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

6 items 23a Director

Funeral

à

Completed

treumstic event, the Medical Examiner must be notified at

"natural", or

pernit. Pages 1 and 2 should be flied within Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than any injury or other treumetic avant

Physiclan /Medical

Examiner

the Marylend

filed within 72 hours after

Baltimore, Maryland 21215-0020

Certifying Physician: To the best of my knowledga, daath occurred at the time, date and placa, and dua to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Cartifian (Check only one)

290.	Signatur	eano	titia of	certifiar
		11		

29c. Licansa numbar

29d. Data signad (Month, Day, Year)

C

1-0013824

1-4-00

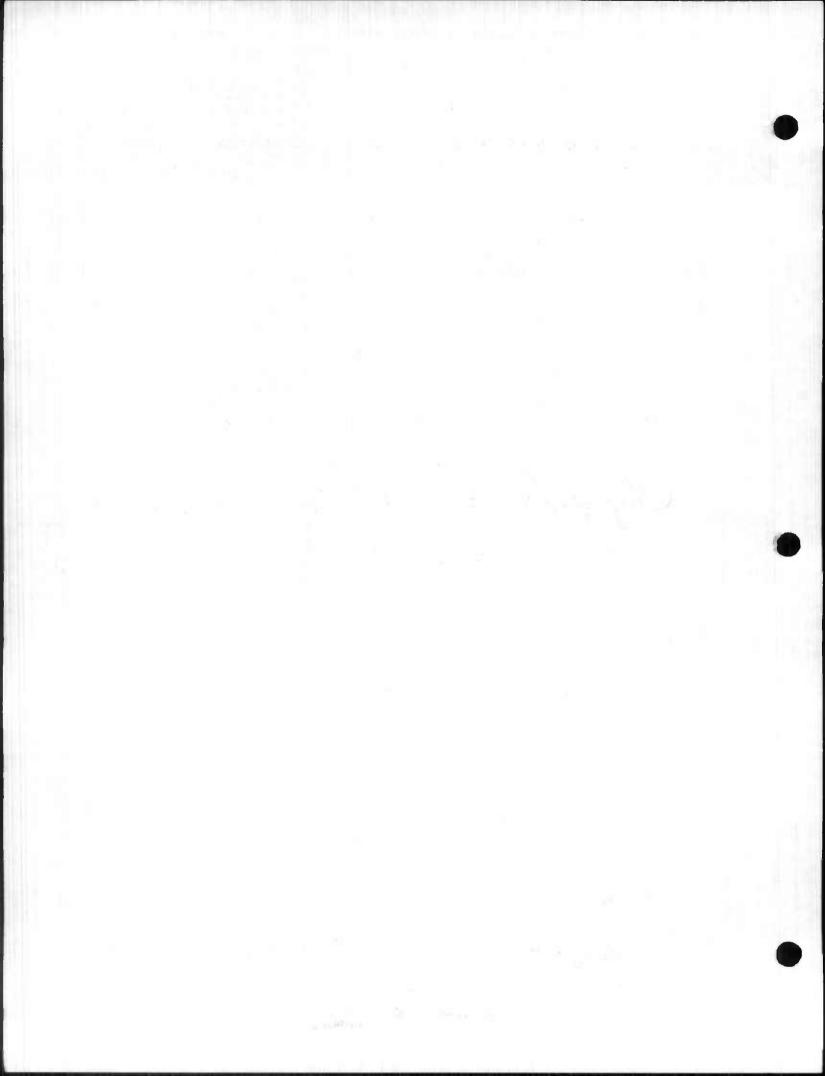
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

John Seymour 122 Speer Road, Suite 5, Chestertown, MD 21620 31. Data filad (Month, Day, Yaar)

State Registrar

2000 JAN





Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Dev Month Year WILLIAM R. 2000 8:00 p.m. Jan. 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Moran Manor Nursing Home Westernport If Undar 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Allegany 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 10XM 2□ F Months Days Yrs 232-26-2116 81 Sept. 8,1918 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 178 E. Piedmont Street 26726 USA 11. Maritai Status 12. Was Decedant Evar in U,S. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Biack, White, etc. Armed Forces 1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Eiementary/Sacondary (0-12) Cottage (1-4or 5+) 9 Signal Maintainer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas C. Gerard Carrie Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Faith J. Gerard/Wife 178 E. Piedmont Street Keyser, WV 26726 20a. Method of Disposition 20b. Placa of Disposition (Nama of cametary, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jan. Queen's Point Cemetery 2000 Keyser, WV 21. Signature of Funaral Servica Licensee 22. Name and Addrass of Facility Smith Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. 26726 Approximate Interval Batween Onset and Death Immediate Cause (Finai myocartial disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, teading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Wara autopsy findings available prior to complation of causa of death? Antimitive Pulmon 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicai 26. Piace of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

28a-1

23a or

or items

"natural",

al Hygiene.

traumatic

Pages 1 and 2 should be nent of Health and Mental is marked o

permit. Pages 1 and 2: Depertment of Health ar important: if item 27 is any injury or other trau

the Medical Examiner must be notified at

Directo

Funeral

Completed by

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed 6 signed l certificate or Attending Physician: After this Certification: To the Hospital or Attending within 24 hours efter death.

To the Funersi Director: After completely filled in by the fun

Physician/Medical

þ

Completed

Be

2

edical

3

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

4 Homicida

(Check only

5 Pending investigation

6 Could not be

Division of Vital Records, P.O. Box 68760,

10 MAS State

Registrar

Jesus Tan, M.D. 31. Date filed (Month, Day, Year) JAN 1 0 2000

29b. Signature and title of cartifiar

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg Plaza 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Frostburg, MD

28c. Injury at Work?

1 Certifying Physician: To tha best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and mannar stated.

29c. License number

1 ☐ Yes 2 ☐ No

D21244

28d. Describe how injury occurred

21532

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

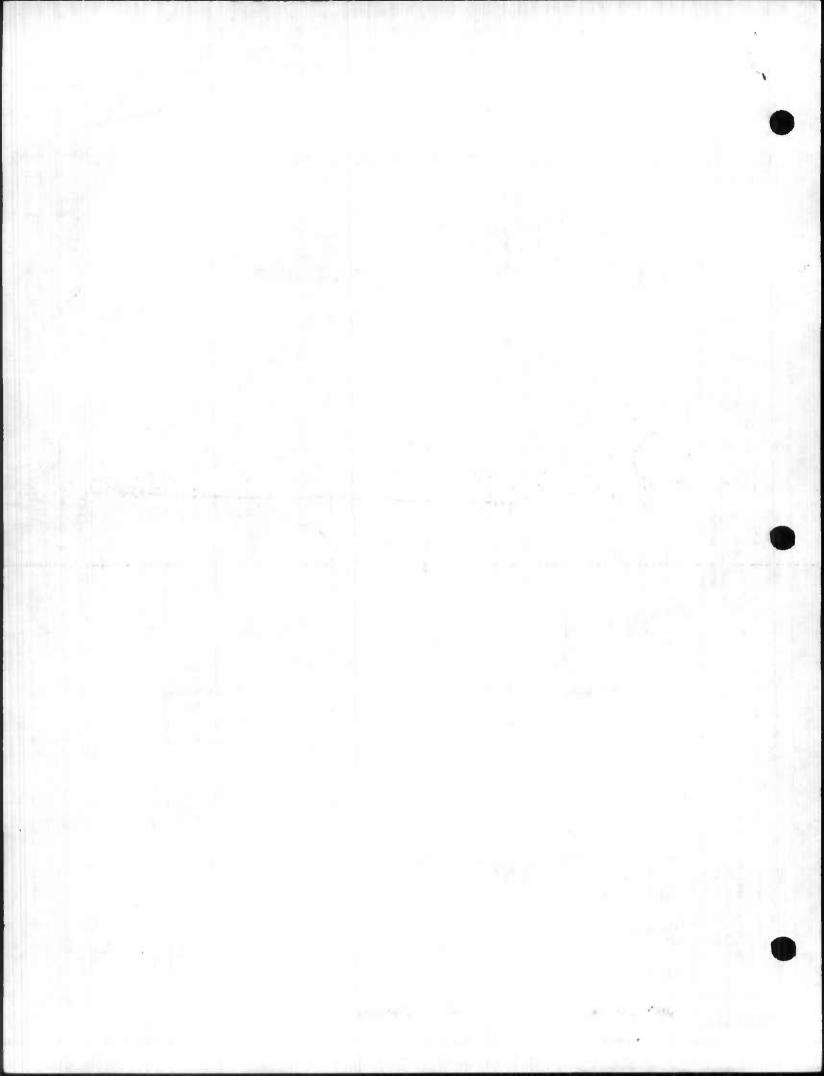
DHMH 16 Rev 6/95

nany d. J. 192

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Vaar **Physician** 2, 0745AM Lewis Graham January 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunbridge Care Elkton Cecil 6. Sex ★★M 2□ F 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours Min 221-14-2073 79 Director Sept.12,1920 Minquadale, Usual Rasidence of Decedant DE 10a State 10b. County 10c. City. Town or Location 10d. tnsida City Limits #Pd# 1 Yas XXNo Director 258-1 New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð munt be. Nerne 23a Funeral 506 6th Avenue 19808 USA t4. Race - American Indian. 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Black, Whita, atc. 72 hours after 1X Yas 2 No 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yas 2ONo Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: WWII white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Hygiene. other then "n Elementary/Secondary (0-12) Collega (1-4or 5+) Stores Attendant General Motors marked other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental I Ernest Graham Anna Baker 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) important: If item 27 any injury or other tr 506 6th Ave. Sara V. Graham (wife) Wilmington, DE 19808 20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematery, cremetory or other plece) 20c. Location - City or Town, Steta XX Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gracelawn Memorial Pk 1/6/2000 New Castle, DE 21. Signature of Funeful Survice Moon 22. Nama and Addrass of Facility McCrery Funeral Homes, Inc 3924 Concord Pike Wilm., DE 19803 23a. Part1. Entar the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Ceuse (Finel disaasa or condition rasulting in daath) Acute Renal Failure Examiner Due to (or as a consequence of): Examine CAD physician end the burial-transit Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initieted avents resulting in death) Last Dua to (or as a consequence of): Box 68760. Prostate Cancer that the death certificate be Physician/Medical Dua to (or as a consequence of) 93 Diabetes Mellitus 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown signed bed bet Records, þ should should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 94 20 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manpar of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of Certification: 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigetion 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

| Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certific 29c. Licensa number 29d. Data signed (Month, Day, Year) C30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Clasque De 34 32. Registrar's Signatura Registrar



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month Day Year **Physician** Rita Grenke 1, 2000 18:15 /Medical January 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland
| If Under 24 Hrs. |
| Hours | Min. | Allegany Memorial Hospital If Under 1 Year 8. Data of Birth (Month, Day, Year) Aug 8, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 74 215-80-6743 Director Aug Usual Rasidanca of Dacedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director r 28a-t Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? iner must be n 21502 11304 Valley Road NE USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Baca - American Indian 11. Meritel Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Nevar Married 2 ☐ Merried 1□Yes 2□No Baltimore, Maryland 21215-0020 Specify Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Name (First, Middle, Last) 89 Frank Henry (Farrel) Carrie 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) of Health at. vot. if Item 27 is a Laura Headley 12102 Shadoe Hollow ; Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 1 Qurial 2 Cramation 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Restlawn Memorial Gard1/05/ LaVale, MD 21. Signaturatof Funeral Service Licenses 22 Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Finai disaasa or condition rasulting in death) /Medical 5 4RS. WHONIC OBSTRUCTIVE LUNG Examiner Dua to (or as a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760. attending physician Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 XNo 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has 1 Yas 2 No 1 ☐ Yas 2 No Grenke this certificate of Vitai Physician: 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After t Division or Attanding 5 Panding investigation t Natural 1 Yas 2 No death. 2 Accident To the Hospital or Attance within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be datarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 | Homicida 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier completely (Check only one) 29b. Signetura and titla of certifian 29c. License number 29d. Data signad (Month, Day, Year) 5 tenera January 5 D0014865 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print))us Robustiano J. Barrera Memorial Med. Bldg. 500 Memorial Ave. Ste. 201 Cumberland 31. Data filed (Month, Day, Year)
JAN 0 7 2000 32. Registrar's Signatu State Registrar

215-80-6743

Rita

11.111 2 11 21/1

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 5, **Physician** FLORENCE **GALLOWAY** 2000 10:36 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (Il not institution, give street and number) 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2♥F Months 59 218-34-6699 Director Dec.31,1940 Maryland Usual Rasidence of Dacedant the Maryland r 28a-f show inotified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 NNo Director Maryland | Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Nerma 23a 6827 Picnic Woods Road 21769 United States Funeral 12. Was Dacedent Ever In U,S. Armed Forces?

1 Yas 2 No If Yas, Giva Yaar or Datas: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Item adical Examiner filed within 72 hours after Hygiens. Oher then "neturel", or its 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 co-operator Family Business permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyp.
Important: If Item 27 is marked other
any Injury or other traument. 18 Mother's Nama (First Middle Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be Ida Weaver Albert W. Fierstein, Sr. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 6827 Picnic Woods Rd., Middletown, MD 21769 Melvin E. Galloway / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 1/8/99 Frederick, Maryland 21. Signature of Funeral Service Licensea 22. Name and Addrass of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Entar the disaasa, or complications that caused the shock, or haart failura. List only ona causa on aach lina Approximate Interval Between Onset and Death Denot entar tha moda of dying, such as cardiac or respiratory arrest, **Physician** Immediata Causa (Finat disaasa or condition rasulting in daath) /Medical Metastatic months **Examiner** Dua to (or as a consequence of): Examiner physician and the burial-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case rafarred to medicat axaminar? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After or Attending Naturat 5 Panding Invastigation n 24 hours after death.

Ne Funeral Director: After pletely filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homleida To the Hospital of within 24 hours at To the Funeral D completely filled in t Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. edicai 29a. Cartifian 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Stormure and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D44164 A. Z. HEGAZI,MO 1-6-00 TOLLHOUS Ave, Bd F, Frederick MD 21701 30. Nama and addrass of person who complated causa of daath (flem 23a) (Type, Print)
A-2-HECAZI 801 TOLLHOUS AWE A-2. HECAZI 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JAN 07 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Verna C. Howell January 7, 2000 1831 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Sacred Heart Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Euneral** Months 220-10-8643 1□M 25 F 84 Yrs. Director 8,1915 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural", or itema 23a or 28a-f show eny Injury or other traumatic event, the Mexical Exercises must be indified and before 10c. City, Town or Location Lonaconing 10a. Stell and Allegany 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 15714 Rockville St. S.W. 21539 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 € No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 Never Merried 2 Married 1□ Yes 25 No Baitimore, Maryland 21215-0020 Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Labor Textile 12 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Meiden Sumame) Be С. Jacob Click Priscilla. Powel1 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Neme/Relationship (Type, Print) Mary Jane Clarke-Niece 13017 Thyme Ct., Germantown, Md. 20844 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Date Jan.10 1 Burial 2 Cremetion 3 Removal from State Frostburg Mem. Park Frostburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, Md. 21539

The contract of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest rick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Merlenslan Records, à Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 20 No 2 ER/Outpetient 3 DOA 1 Inpatient this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Affer 5 Pending Investigation 1 Natural
2 Accident To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier completaly (Check only one) 29b. Signature and major certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10 Wo Crevers ne and address of person of death (Item 23a) (Type, Print) My Cumberland Setor nomas 1 2000 Registrar's Signature State Registrar

The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\cap \)

					Cer	tificate of	Death		Reg. No.	1,0	6.04	
	9	1. Decedent's Name (First, Middle	, Last)					2. Date of De		Veer	3. Tima of Death	
Physic /Medi		SHIRL	EY	KAY]	HEFFLE	Y	Jan.		OOO	6:00 AM	
Exami		4a. Facility Name (If not institution	, giva street and number	r)			4b. City, Town, or t					
		1710 Abel:	ia Road				Falls	ston		Harf	ord	
Funeral Director		5. Social Sacurity Number 275–40–6718	6. Sex 1 □ M 2 ▼ F	ige (In yrs. las. 54	t birthday) Yrs.	Months Days		8. Date of Bir (Month, Da 2/26/	th L945	9. Birthple Counti	oce (Stata or Foreign (Y) Ohio	
aryland show	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	eation				10	d. Inside City Limits	
M e M	ecto		Harford				Fallst	on				
th with the Maryle 23a or 28a-f show	rai Dire	10e. Street and Number 1710 Abel:	ia Road			10f. Zip Code	21047	,	10g. Citizen of \	What Countri J.S.A	•	
11215-0020 within 72 hours efter death with the Manyland ene. Then "natural, or items 28a or 28a-f show than "natural be notified at	by Funeral Director	11. Marital Status 1 Nevar Married Marri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? [No		/as Decedent of Yes, specify Cul	Hispanic Orlgin? (Span, Maxican, Puert Specify:	pecify Yas or No o Rican, etc.)		e - America ck, White, e		
21215-0020 d within 72 hours ef giene. ir then "natural; or the Wed	Completed	15. Decedent (Specify only highes	t grada completed)		(Giva I	ent's Usuai Occu kind of work done O NOT use retire	during most of wor	king	16b. Kind of B			
ore, Maryland 212: s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumetic syent, the M	Comp	Elemantary/Secondary (0-12) Colia —		5+)	Secretary			Harfo:		rd County		
D SECTION	Be	17. Father's Name (First, Middla, I	Ast)				18. Mothar's Nan	na (First, Middle	, Maiden Suman	10)		
aryian should be and Mental marked o	L 2	Charles		Hine	dere	r	Berd	lena		Po	unds	
Maryiand d 2 should be file th and Mental Hy 7 Is marked othe traumetic svent,		19a. Informant's Name/Relationsh					t and Number or Ru			State, Zip (2ode)	
ore, Maryland 2 st and 2 should be filed for Health Hyging of Health Hyging them 27 is marked other coher traumede avent,		George R. He	effley/Hu			ame as	#10 a, k	,c,e,1		0. 7	0	
S = 2		1 ■ Burial 2 □ Cramation 4 □ Donation 5 □ Other (Sp		cem	etery, cram	atory or other pla	,	175	Fallst			
Baltim permit. Pe Departmen Important: any Injury once.		4 Donation 5 Dother (Specify) Highview Mem. Gardens 2000 Fallston, Maryl: 21. Signature of Funaral Service Licenses E.G. Kurtz & Son Funeral Home, P.A Jarrettsville, Maryland										
		23a. Part1. Enter tha disease, or complications that caused in death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate the provided by the cause on each line.										
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. OU	ano	5	Car	cer				Onset and Death 5 YEARS	
D 4	ner	Due to (or as a consequence of):								1		
and Frans	Examiner	Sequentially list conditions,	b	Due to (or as	s a consequ	ance of):				1		
60, be ey										i		
. Box 68760, death certificate be executed e attending physician and ad for use as the burish-transit	edical	that initiated events resulting in death) Last		Due to (or as	a consequ	ence of):						
Box nath certi	N/	•	d									
BOY death ce attended of for use	Cia	Part II. Other significant condition	se contributing to death	but not recultir	og in the un	domina cause a	iven in Dart I	23h Did	tohacco use co	ntribute to	the cause of death?	
P.O.	by Physician/	Breast cancer							Yee 25 No		ably 4 Unknown	
requestion should	Completed b								an autopsy nmed?	avai	ra autopsy findings lable prior to spletion of cause eath?	
Vital Revictor: The law certificate has rector, page 2	E							10	Yes 2 No		Yes 2□ No	
of Vital Re Physicien: The is this certificate ha ral director, page	Bec	25. Was case referred to medical					26. Placa of Dea		-		700 2010	
- Z 0	ToE	examiner?	Hospitai: 1 ☐ Inpat	ient 2□ER	/Outpatient	3□ DOA O	bar	-	dence 8 □Oth	er (Specify)		
n of ag Physic recthis neral di		27. Manner of Death 1 Naturat 5 □ Pending	28a. Date of Inj (Month, D	ury 28	b. Tima of tnjury	28c. Inju	iry at	28d. Describe	how injury occur	red		
VISION Attending or death. ector: After	atic	2 ☐ Accident investig	ation	,,	,,	M 1 Yas 2 No						
Division al or Attending I s efter death. I Director: After	Certification:	3 Sulcida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)						28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,	
Division or To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and mannar s	of axamination	dge, death and/or inve	occurred at tha t estigation, in my	ima, data and place opinion, death occur	and due to the rred at the tima,	cause(s) and ma data and piace,	inner as sta and due to t	ted. the cause(s)	
To the To the comp	M	29b. Signature and title of certifiar	Chau	de	ym.	29c. Licen	se number	6	29d. Data signe	Month, D	ay, Year)	
13		30. Name and addrass of person w	no completed cause of	death (Item 23	Sa) (Type F	OUAR!	E HOSPIT	TAL CE	NIER	ORF	MD 21237	
Sta	ite	31. Date filed (Month, Day, Year)	32. Pagist	rar's Signature	ריתו	NUN	J4-11-10 L	THE THE				

Registrar



was equity to the way and the war

Piease Type or Print In Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death January 5, 2000 Ruth Suzanne Hogans 11:15 a.m. 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death 7030 Swan Creek Road Rock Hall Kent If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | 9. Birthplace (State or Fora Months | Days | Hours | Min. | April 12, 1928 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 1□M 2XF Months 71 Yrs. 189-24-3509 Usuei Residance of Decedant 10a State 10b. County 10c. City, Town or Location 10d, Insida City Limits 1 Yas 2 No Maryland | Kent Rock Hall 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7030 Swan Creek Road 21661 USA 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armad Forces? Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own home 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Robert L. Corbett Gertrude Lascheid 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Reletionship (Type, Print) Frank Hogans, Sr./Husband 7030 Swan Creek Road, Rock Hall, MD 21661 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Steta 4 Donetlon 5 Other (Specify) Chesapeake Cremation Center, LLC 1/6/00 Stevensville, Maryland 22. Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signatura of Funaral Service Licensea 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one on see on each line. Approximete Intarval Between Onsat and Death fmmediete Cause (Finel disaasa or condition rasulting In daeth) Hyportensive ArtoroSclovotie Cardio Vascular Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that in itiated avants rasulting in daath) Last Dua to (or as e consequança of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes ANO 3 Probably 4 Unknown Elevated Cholostevol, Osteopenia 24b. Wara autopsy findings availebla prior to completion of causa of death? 24a. Was an autopsy performed? the Tachycardia, 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Place of Daath (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 20KNo 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28e. Deta of Injury (Month, Day Year) 28b. Tima of 1. Neturel 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant

physician end s the burief-trens Division of Vital Records, P.O. Box 68760, USB

Physician

/Medical

Examiner

Examiner

by Physician/Medical

Completed

Be

Certification: To

Medical

or Attanding Physician: effer death. Director: After this certific funeral director.

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

Hem 27 is marked other than "natural", or hams 23a or 28a-f ahor other traumatic event, the Medical Examiner must be notified at

the Merylend ahow

25. Wes casa rafarrad to medical axaminar?

3 Suicida

29e. Certifier

4 Homicida

investigation

6 Could not be determined

28e. Pleca of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, data end plece, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of axaminetion end/or invastigetion, in my opinion, daath occurred at the time, data end place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifian 600 an Ow

29c. Licansa number D 50996 29d. Data signed (Month, Day, Year)

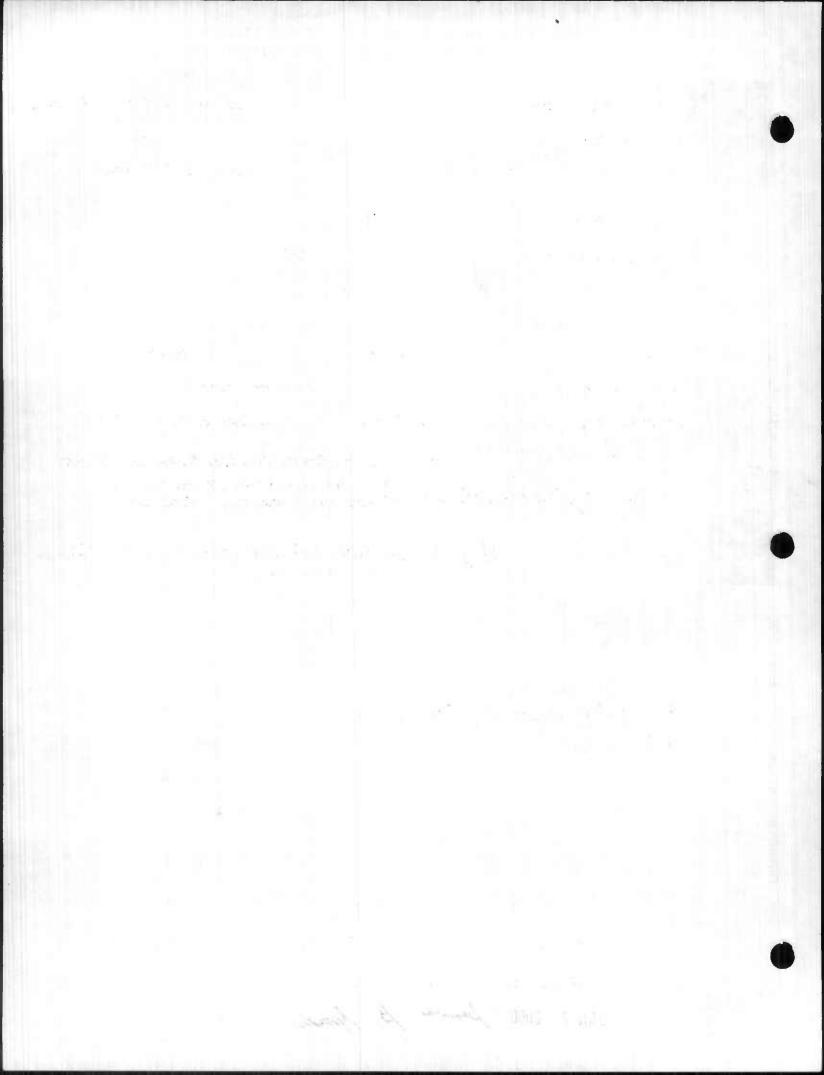
30. Nama and addrass of person who completed causa of daeth (Item 23e) (Type, Print)

Neil Stoddard, 100 Brown Street, Chestertown, Maryland 21620 31. Deta filed (Month, Dey, Yaar) 32. Registrar's Signeture

State Registrar

124 hours e Hospital

Within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOYCE HOLDEN Jan. 3 2000 7:10 PM /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore 5 Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 10 M 20 F Director 217-36-0924 61 September 5, 1938 Chestertown, Maryla Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nos 2 No Director Marvland | Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 508 Morgnec Road Herna 23a 21620 USA deeth Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Heelth end Mental Hygiene.
III: If item 27 is marked other than "r.
III: or other traumatic event, trailling Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilfred Thomas Holden Bertha Dora Taylor 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mary Ann Taylor/Sister 508 Morgnec Road, Chestertown, Maryland 21620 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Department Important: If any Injury or stick. 1/8/00 4 ☐ Donation 5 ☐ Other (Specify) Church Hill Cemetery Church Hill, Maryland 21. Signature of Faneral Segrice Libers 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620
Approximate caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest.

Approximate Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Asystole Examiner Due to (or as e consequence of): Examiner ician and burial-transit Anterror Mycardial Infarction the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician the burial Box 68760. Physician/Medical Due to (or es a consequence of): 50 for use a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed page 2 2 (X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 💥 No 1X Inpatient 2 ☐ ER/Outpetient 3 DOA sly 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27 Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending investigation or Attending 1X Naturel r death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State

completaly

within 2 the

> 31. Date filed (Month, Dey, Year) 2000 Registrar JAN 7

Greene

(Check only one)

29b. Signature and title of certifier

St Bottomore, 32. Registrer's Signeture

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

MO

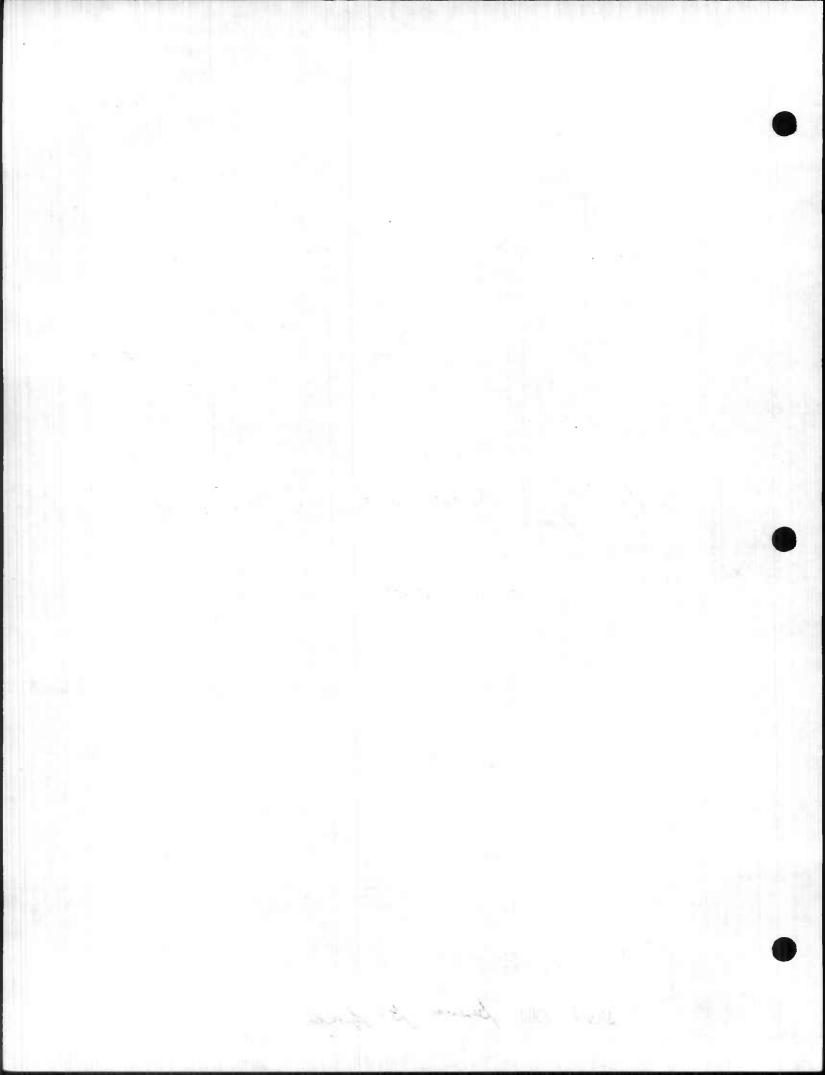
2120 MD

29c. License number

11660

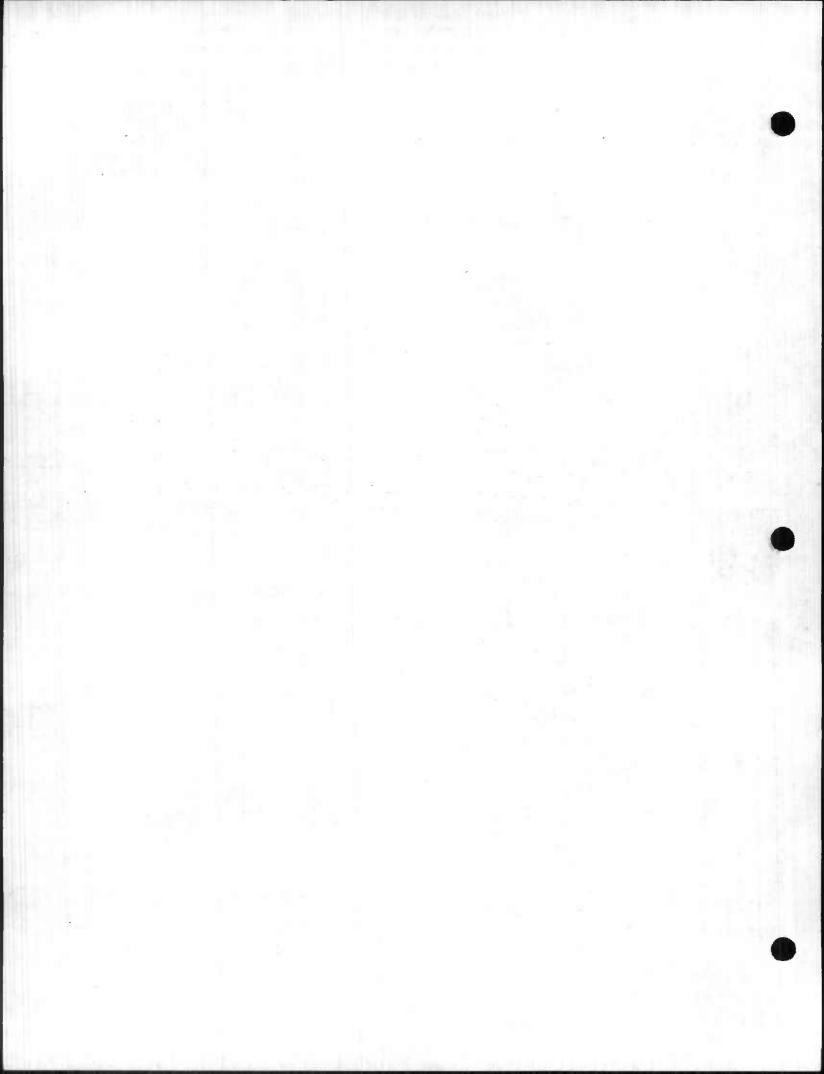
29d. Date signed (Month, Day, Year)

1/06/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 2 7

						Certif	ficate of	Death		Re	g. No.		516.07	
			1. Decedent's Nema (First, Middla, Las	st)						2. Date of Death	1		3. Time of Death	
	Physicia		Mary Edith Hancon							Month	Day	Year 2000	0907	
/Medic Examin			At City of the Cit						wn, or Lo	ocation of Death	4c. County			
4	LAGIIIII	ici	Washington (County Ho	ospita	1		hage	rsto	าพท	Wash	ingt	on	
	Funeral		5. Social Security Number 6. S		a (In yrs. last bir	thday) II	f Under 1 Yaar	If Undar	24 Hrs.	8. Dete of Birth		9. Birthol	lace (State or Foreign	
	Director		216-22-1718 Usual Rasidence of Decedani	OM 20 F 75		Yrs. M	Months Days	Hours	Min.	Feb. 28,	1924	Mary	(DY)	
	yland										0d. inside City Limits			
	Me I	ţ	Maryland Washin	gton	Hager	stown	n					9/1	1X Yas 2 No	
	1 28	9	10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country?									try?		
	death with the Meryland me 23a or 28a-f ahow man be notified at	0	247 N. Mulberry	Street			21740				USA			
	deat deat	Funeral Director	11. Marital Stetus	12. Wes Decedent E	Ever in U,S.	13. Wes	s Decedent of I	lispanic Ori	gin? (Sp	ecity Yes or No-		ce - Amarica		
21215-0020	72 hours after death with the Merylan natural", or items 23s or 28s-1 show	by Fu	1 Never Married	Armed Forces? 1 ☐ Yas 2 ☑ N If Yas, Giva Yeer or Dates:	lo		as, specify Cub Yas 210 No			rican, atc.)	Specify	ck, White, e		
0-0	natural.	9	15. Decedent's Ed		16a.	Decedent	t's Usual Occup	pation		. 1	6b. Kind of B	usiness/Ind	lustry	
215	2	Completed	(Specify only highest grade Elamentary/Secondary (0-12)	de completed) Collega (1-4or 5-	4)	lifa. DO	d of work dona NOT use retire	aunng mos d)	t of work	ing				
21	37 00 5	PO	8			Iousev	wife			Home				
B		Be	17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First							(First, Middle, M	laiden Suman	na)		
19	should be and Mental marked o	To	Daniel Fr	anklin Mul	ligan			Mar	v Ad	a Barger				
Maryland	d 2 sho h and h 7 is me traumer		19a, Informant's Name/Ralationship (7			. Mailing A	Addrass (Street	and Number	er or Run	al Routa Number,	City or Town,	Stata, Zip	Code)	
	0 5 h 5		Alfred W. Henson	Husba	and 24	7 N.	Mulber	rv St	reet	Hagers	town.	Marv1	and 21740	
re,	ges 1 and it of Health If item 27 or other ti		20a. Method of Disposition		20b. Place of	Disposition	on (Nama of ory or other pla				Oc. Location			
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				Cemete		1/	5/00 ha	gersto	own, M	Maryland	
	교투원증.		21 Signature of Funeral Service Licen	-	^		eme and Addra				0			
B	Depa impo any i		N. ON	Muni	U	Gera	ald N. 1	Minnic	h	305 N. I	Potomac	Stre	eet	
		-	23a, Part1. Enlar Iha disaase, or comp shock, or heart feilure. List only o	liantions that savead	the death Day	Fune	ral Hor	ne	esetine.	Hagersto	wn, Ma	rylar	nd 21740	
			shock, or heart feilure. List only	ona ceusa on aach lin	a.	not emar tr	ne mode or dyr	ng, such es	Cardiac	or respiretory arre	51,	1	intervel Between Onset and Death	
	Physician / /Medical		tmmediala Ceusa (Finel		Λ	1	1-	1-						
	Examiner		disaasa or condition rasulting in daath)	a. My	ocard	ul	infa	setu	~			- 1	10 min	
п		-		010	Dua to (or as a	consequer	nce of):	- D	1	1 . 1				
	De fisc	Examiner		b. Chro	mic	Con	assine	- h	earl	Larly	ne		1.4	
	and I-trar	хаг	Sequentially list conditions, Dua to (or as a consequence of):									U		
68760,	icate be executed physician and s the burial-transit	al	Cause (Disease or injury							litus		i	10 yrs.	
87	rtificate be ng physicia i as the bur	edicai	that initiated evants resulting in death) Last	0	Due to (or es e	consequen	nce of):					į	0	
	200	2		d.								i		
Box	death ce e attendi	la l										1		
	v requires that the death ce been signed by the attendi should be detached for us	Physician/	Part II. Other significant conditions co	s contributing to death but not resulting in the underlying ceuse given in Part I.						23b. Did tobacco use contribute to the cause of death?				
P.0.	that the seed by detact	4	Lupertension							1 Yes 2 No 3 Probably 4 Unknow				
JS,	signe be d	þ	Goyper	0,000								T		
0	v requires been sign should be	9	v							24e. Wes an perform		SVE	are autopsy findings allable prior to mpletion of cause	
9	law es b	Completed									-		death?	
Œ	The page	5								1□ Ye	s 2 No	10	Yes 2□ No	
Vital Record	Physicien: The law this certificate hes ral director, page 2	Be	25. Was cesa referred to medical axaminer?					28. Place	of Deat	h (Check only one	1)			
1	Physic this ce	2	1 Yes 2 No	Hospital: 1 Inpatiar	nt 219 ER/Ou	tpatient	3 DOA Ot	her: 4 Nu	ursing Ho	ma 5 Reside	nce 6 DOth	ner (Specif)	y)	
1 0	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day		Tima of njury	28c. inju Wo	ry at		28d. Describe ho	w injury occur	red		
0	death. ctor: Aff y the fur	atio	1 ☑Natural 5 ☐ Panding 2 ☐ Accidant investigation	, , , ,	, ,			Yes 2	No					
Division	Attending or death. ector: After by the fune	Certification:	3 Suicida 6 Could not be detarmined	28a. Piece of mju		ırm, streat,	, fectory, office	E		28f. Location (Str. City or Town,		ber or Rura	l Routa Number,	
0	a after a safter a Director	E E	4 B Homoda	building, atc.	. (Specify)					ony or rown	, Oldio,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	18	29a. Certifier 1 Certifying Phy	velcian: To the best of	f my knowledge	, daeth oc	curred at the ti	me, dala an	d place,	and dua to tha ca	use(s) and ma	anner as st	lated.	
	n 24 n 24 ne Fu	edical	(Check only 2 Medicat Exam	iner: On the basis of end mannar stat	examinetion an ted.	a/or invest	tigetion, in my o	opinion, dae	in occurr	ed at the time, da	te end plece,	and due to	the cause(s)	
	within To the comple	ž	29b. Signeture and title of certifier	0 .	1 1 1	1	29c. Licens	se number		29	d. Dala signa	d (Month, I	Day, Year)	
			Har	NU	UVU		V	50-	13	8	1/3	100		
		-	30. Neme and address of person who o	completed causa of de	eath (Item 23a)	(Type, Prin	nt)		1		1	, 0		
			Dr. Sandra 3	towler	20-	nnH	6 600	T	1+	. Has	a. md	. 3	1740	
	Stat	te	31. Data filed (Month, Day, Year)	32. Régistra	r's Signature	4	1	1	1	1.41				
	Dominto	21	JAN 11 6 201	1 A STATE	1	V.	ROPO M	-/						



Piease Type or Print in Biack Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day RICHARD HULL **OSBORNE** January 6 2000 1600 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 645 Knights Island Rd. Earleville Ceci1 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) June 25 1923 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 12 M 2□ F Months 76 186-12-1615 Pennsylvania Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ceci1 1 ☐ Yes 2 No Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 645 Knights Island Rd. 21919 U.S.A. 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No White Specify: 3X Widowed 4 ☐ Divorced 42 - 4516a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Delivery-Truck Driver 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David Hull Roxie Rabenstine 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sean Hull (son) P.O. Box 611 Cecilton, MD. 21913 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from Stete Capitol Crematory 1/9/00 Dover, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. 21635 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart faiture. List only one cause on each line Onset and Death Immediate Cause (Finel disease or condition resulting in death) ardiomyopa duos Due to (or as a consequenca of) 3000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) brillation MICH Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yaa 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Assidence 6 Other (Specify)

26. Place of Deeth (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

8

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglens. Important: If Item 27 Ia marked other than "natural", or item eny injury or other treumatic event, the Medical Exemples.

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical by

25. Was case referred to medicat examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide 4 I Homicide

(Check only one)

29b. Signature and fittle of certifing

29a. Certifie

1 Maturat

physician and s the buriel-transit certificate be 8.8 180 signed by t d be detach peed certificate has this : After this

Box 68760. P.O. Records, Division of Vital

Completed 8 P Ne Hospital or Attending Pin 24 hours after death.
The Funeral Director: After to classified in by the funeral Certification: To the Hospital o within 24 hours af To the Funeral D complately filled is adical

MITIVA

State

Registrar

address of person who completed cause of death (Item 23a) (Type, Print) w. Hig 5+ 31. Days filed (Month, Day, Year) JAN 11 2000

Nu

5 Pending investigation

6 Could not be determined

Hospitel:

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

EI Bocks

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

1 Yes 2 No

716

Kton

Stymale I vice of the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Edward Kenneth Harvey, 3 2000 JANUARY 9:58 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Hours 1₩ M 2□ F 232-09-5391 86 Sept. 28, 1913 Maryland Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Md Nas 2□No Garrett Bloomington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 Hampshire Ave. 21523 United States Was Decedent of Hispanic Origin? (Specify Yas or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give 1 Never Married 20 Merried 1 Yas 2√ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paper Mill Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Edward Franklin Harvey Ina Mae Davis 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dora Harvey / Wife 239 Hampshire Ave. Bloomington, MD 21523 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete Bloomington, Md Bloomington Cemetery 1/6/00 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility 111 Church St. aun Boal Funeral Home 21562 Westernport, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Finel MERE disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): Part II. Other/elignificant conditi commeuting to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

8

Director

Funeral

py

Completed

B

Funeral

Director

ahow

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Manyland

death with

72 hours after

d 2 should be filed within 7, th and Mental Hygiene.
T is marked other than "na

Pages 1 and 2 should be nent of Health and Mental

nt of Health a : If Item 27 is

permit. Page Department of Important: If any injury or once.

aitimore, Maryland 21215-0020

burlal-transit physician s the burlai been signed by the a should be detached f director. funeral

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vitai or Attending Physician: Examiner Physician/Medical Completed by Be P

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th

After this

deeth.

after death Director:

nos State Registrar

Certification: 29e. Certifier (Check only one) Medical

BXPBCTE 25. Was case referred to medicat examiner? 1 Yes 2 No

27. Manner of Death 1 Netural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Dete of tnjury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28t. Location (Street and Number or Rural Routa Number, City or Town, Stete)

28d. Describe how injury occurred

26. Place of Death (Check only one)

29c. License number DXA RUO

12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner as a fact.

29d. Date signed (Month, Day, Year)

JANUARY <

2 No

2000

1 ☐ Yas 2 ☐ No

Robert Welik Mp 902 Seton Drive

29b. Signature and title of certific

4 ☐ Homicide

32. Registrar's Signature

Cumberland, MD 21502

DHMH 16 Rev 6/95

16H 0 7 (200)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANVARY **Physician** 0546 AM RUTH ELIZABETH 2000 HOFFMAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Country) | MARCH 15, 1923 | PENNSYLVANIA 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs 203-12-0718 76 Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location r 28a-f show a notified at 10d. Inside City Limits the Marylar ahow 1 ☐ Yes 2 No Directo MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or hams 23s or 19833 HARMONY HILL LANE 21713 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify ğ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Department of Health and Mental Importants of Importants if New 27 is marked or any Injury or other traumatic ever 2059. 2 ROBERT (UMN) BLACK HILDA (UMN) MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19833 HARMONY HILL LANE, BOONSBORO, MARYLAND 21713 PAUL W. HOFFMAN/SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 1/4/2000 BOONSBORO, MARYLAND 21. Signature of Kuneral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final 7AIL URS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner VISCUSE Thero 20 physician and a the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? irector, page 2 s 20 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physicien: 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 유 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1) Natural 5 Pending n 24 hours efter death.

Ne Funerel Director: After pletely filled in by the fun 1 Yes 2 Ne 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DO011266) An 2000 dead 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) HAGEYSTOWY. Nextuo

State Registrar

31. Date filed (Month, Day, Year)

JAN 05 2000

21215-0020

ELEZ ABETH

RUT

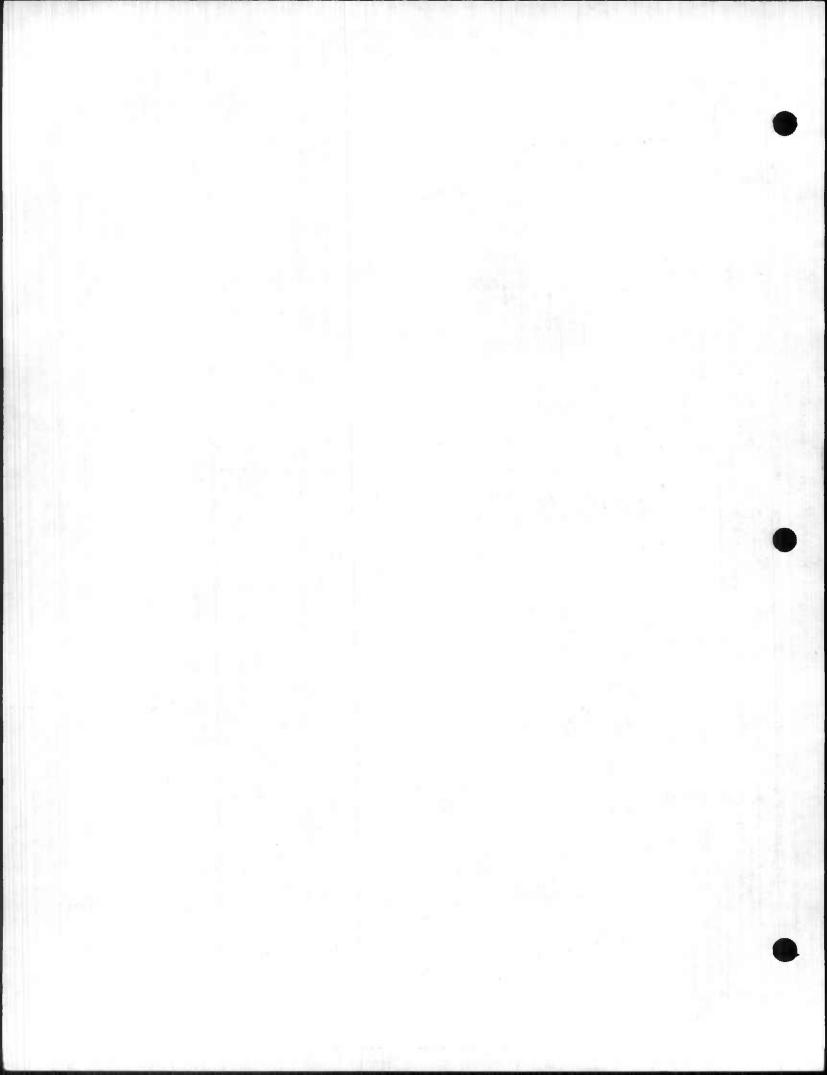
FOFFMAN

Box 68760.

P.O.

Records,

Division of Vitai



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2000 Jan 7, Lewis Woodrow Hook 12:23pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Cumberland Nursing Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Jul 11, 1913 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign Months Days Hours 1 M 2□ F 215-12-2062 86 Yrs. Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Ves 2 □ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Paca Street Apt. 305 21502 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Navar Married 2 Married 1□ Yes ⊋□ No Specify: Specify: white X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Retired employee CSXT Corporation 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Isaac M. Hook Georgetta (Hymes) 19a. Informant's Name/Relationship (Type, Print) Ada Cutlip 19b. Malling Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) P.O. Box 188; Wiley Ford, WV 26767 P.O. Sister 20a. Method of Disposition 20b. Piece of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/11/ Artemas, PA Fairview Cemetery 21. Signetura of Funarai Sarvica Licansee 2Scarpers Fruneral Home P.A. Cumberland, Maryland 23a. Part 1. Entar the disease, or complications that caused if shock, or heart failure. List only one cause on each line d the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, Approximate Intarval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) Coronary Artery Disease 5 years Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Chronic Obstructive Pulmonary Disease completion of causa of death? 200 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminar? 26. Placa of Death (Check only one) axaminar? Hospital: Othar: Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident

Examiner The law requires that the death certificete be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68760 attanding pl signed by the a d be detached f certificate has b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director.

Physician

/Medical

Examiner

Physician/Medical by Completed Be 2 funeral Certification:

Physician

/Medical

Examiner

Directo

Funeral

py

Completed

Funeral

Director

ir than "natural", or items 23s or the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 284 any injury or other traumatic event. the

with the Manyland r 28a-f show

29a. Cartifier

(Check only one)

6 Could not be determined 3 Suicida 4 Homicida

and manner stated.

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. Licensa number 29d. Data signed (Month, Day, Year)

29b. Signeture end titia of cert

D33280

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Sunil K. 625 Kent Avenue Cumberland MD 21502 Gupta M.D.

31. Date filed (Month, Day, Year) JAN 1 0 2000 32. Ragistrar's Signatura

Registrar

in by

Medical

To the Hospital or within 24 hours aft To the Funerel Di completely filled in

JAN LO 2000 James & Server

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middia, Last) Month Day 1, 2000 8:55 PM January Jones Hanna 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Timonium Baltimore Stella Maris Hospice If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) 1□M 3₽F Months Days Hours Min Yrs. Apr. 6, 1911 88 Virginia 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Aberdeen 10f. Zip Code 10g. Citizan of What Country? 21001 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian Black, White, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Collaga (1-4or 5+) Public Education Teacher 18. Mothar's Nama (First, Middle, Maiden Surnama) Sandridge Nathaniel Lawson Jones Tda (mmn) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 3663 Browns Gap Turnpike, Crozet, Virginia 22932 Lucile J. Stephenson / Sister 20b. Piace of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Mt. Plain Baptist Chr. Cem. Albemarle Co., VA McComas Funeral Home, P.A. april 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enfar fire dilmasa, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear to line. List only one cause on each line. Approximate Interval Between Onsat and Death arkins Disease Immediata Causa (Final disaasa or condition Dua to (or as a consequence of) Sequentially fist conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

law requires

or Attending

To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in b

Examiner physicien and the buriel-transit Physician/Medical 88 esn signed by the a d be detached f þ Completed Be

certificata has b this funeral Certification: After hours after death. ector: by the

10

Part If. Other algorificant conditions contributing to death but not resulting in the underlying ceusa given in Part I.

25. Was cesa rafarred to medical axaminar? 1 Yas 2 No

27. Mannar of Death 5 Panding Invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicida 4 Homicide

28a. Data of Injury (Month, Day Year) 28b. Tima of

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Homa 5 Rasidence 6 Dothar (Specify) HUSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 Yas 2 No

26. Placa of Death (Check only ona)

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and mannar as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, data and place, and due to the causa(s) and mannar stated.

1 Yes 2 No

1 Yas 2 No

28d. Dascribe how Injury occurred

24a. Was an autopsy

29b. Signature and titla of certifiar

29a. Certifier

(Check only one)

29c. Licansa number D43725 29d. Data signed (Month, Day, Year) 3/00

Baltimore MD 21221

3 Probably 4 tonknown

24b. Wara autopsy findings available prior to complation of cause of death?

1 □ Yas 2 □ No

30. Name and address of person who completed ceusa of death (Itam 23a) (Type, Print) 201-109 Back River Neck Road

MAHMOUD 31. Data filed (Month, Day, Yaar)

JAN 0 5 2000

32. Régistrar's Signatura

State Registrar

Medical

TO SEE SEE STATE OF SECURITIES AND ADDRESS OF THE SECURITIES AND A

(D) 12:0 (1:19) (1 / 12)

Dhusiaise	1. Decedent's Name (First, Middle, I	Last)			2. Date of Deat Month	b Dey Year	3. Time of Dea			
Physician /Medical	MELVIN GEORGE	HENRY			1000	January 5, 2000 1605				
Examiner	4a Fecility Name (If not institution, g				r Location of Death	4c. County of Dea	ith			
	SACRED HEART H		to as birds do al. If I had	CUMBER	LAND 8. Dele of Birth	ALLEGAN				
Funeral Director	5. Social Security Number 6. 214 07 1566	7. Age (In yrs. 91	Yrs. Month	s Deys Hours Mi	Month, Day,		rthplace (State or Fo ountry) RYLAND			
ified at	10a. State 10b. County MARYLAND ALLEGAN		y, Town or Location	774			10d. Inside City Li			
or zited be notifie Directo	10e. Street and Number			Zip Code	10	g. Citizen of Whet C	ountry?			
	65 BROADWAY			21532		U.S.				
ar, or litems 23: Examinar must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1		edent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, atc.			
t, the Medical Completed	15. Decedent's (Specify only highest g	suel Occupation work done during most of w use retired)	orking	16b. Kind of Business/Inc						
Co in the	12 17. Father's Name (First, Middle, La:									
To Be	RAYMOND HENRY		40h Mailine Addu	EVA	LOAR		Tin Codel			
2718.0	19a. Informant's Name/Relationship ROSETTA HENRY /	WIFE		uss (Street and Number or F WAY, FROSTBU)			Zip Code)			
other a	20a. Method of Disposition		Plece of Disposition (A			20c. Location - City o	Town, Stete			
7 2 2	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Linemover from State			1/0/00	DOCTRIIDO	MD			
importar any injur	21. Signature of Funeral Service Licensee 22. Neme end Address of Facility SOWERS FUNERAL HOME, P.A.									
	23a. Part1. Enter the demase, or co	modulations that caused the deet	h. Do not enter the m	MAIN ST., F) ode of dying, such es cardi	ROSTBURG, ac or respiretory arre	MD 21532 est,	Approximate			
/sician ledical	Immediete Cause (Final disease or condition	y one cause on each line.	iredor				Interval Between Onset and Dea			
aminer	resulting in death)	Euch	or as a consequence of	plesto e	OPD		10 4			
n and lal-transit Examiner	Sequentially list conditions,	b. Due to (c	or es e consequença o	φ Δ		E/ 1016	1			
sician a burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. 12 2	unee	2.	200					
d by the attending physeteched for use as the Physician/Medic	resulting in death) Last	Due to (o	r es a consequence d	0: /			 			
d for u	Part II. Other significant conditions	contributing to death but not rec	ulting in the underlying	a sousa ciusa in Bod I	22h Did to	becco use contribut	e to the cause of d			
80	Part II. Ourer significant conditions	contributing to death but not res	uiting in the underlying	cause given in Per().	100000000000000000000000000000000000000		Probably 42 Un			
2 should pieted					24e. Wes ar perform	n autopsy 24b.	Were autopsy lind evailable prior to completion of caus of deeth?			
Com					1 🗆 Ye	s 21 No	1 ☐ Yes 2 ☐ No			
s certificate director, pag To Be Co	25. Was case referred to medical axaminer?	Hospital:	41,-24,124	Other	eath (Check only on					
After this funeral di	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		nce 6 ☐ Other (Sp. w injury occurred	ecify)			
al Director: After ted in by the funer Certification:	3 Suicide 6 Could not determine	be d 28e. Plece of Injury - At he building, etc. (Specification)	ome, ferm, street, lectory)		28f. Location (Street and Number or Rural Route Number City or Town, State)					
To the Mospital or Attenwithin 24 hours after deat To the Funeral Director: completaly filled in by the Medical Certifical										
Funeral Cetaly filled	one)		0 1:	20	29d. Date signed (Month, Dey, Year)					
To the Funer completely fil Medical	29b. Signature and title of confiler		29b. Signature and title of confifer 29c. License							
Completely filled	7.13	ecca w	2	DO 837	_	January 6	, 2000			

DHMH 16 Rev 6/95

power to appear

1865 7 6 444

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certific		Death	, ,	leg. No.		
Physicia /Medic Examina		ian	Decedent's Neme (First, Middle, Lest)						Deta of Deeth Month Dev Year			3. Time of Death
			GRAHAM BRADLEY HOULTON						Januar	y 5, 20	00	5:00 AM
		ner	4e. Fecility Nema (If not institution, giva		17 <i>i</i> h -	1			or Location of Death 4c. County of Deeth			
Н			Montgomery County 5. Social Sacurity Number 6. Se		Hospita (In yrs. lest bin		dar 1 Yaar	Olney If Under 24 Hrs	Date of Diet	Montg	_	
Į.	_o Funeral Director		578-44-9000 Usuel Residence of Decedent	X 7. Age		Yrs. Mont		Hours Min.	8. Date of Birth (Month, Dey Jan. 1,	1933	D. C.	ace (Stete or Foreigr ry)
	yland		10e. Stete 10b. County		10c. City, Town	or Location					10	d. Inside City Limits
	e Ma	ctor	Maryland Montgome	ry	Wheat	on						1 X Yes 2 □ No
	23a or 28	Funeral Director	10e. Street and Number 4011 Randolph Roa	ıd			Zip Code 20902		1	10g. Citizan of Whet Country? U.S.A.		
)20	within 72 hours after deeth with the Maryland ilena. Than "natural", or items 23a or 28a-f show the Medical Examiner must be northed at	by Fune	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Moivorced	12. Wes Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Yeer or Dates:	0			dispenic Origin? (S an, Mexicen, Puert Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Amarican Indien, Bleck, White, etc. Specify: White	
21215-0020	2 hou	ed	15. Decedent's Edu	cation		Decedent's U	's Usuel Occupation			16b. Kind of B		
215	hin 7.	Completed	(Specify only highest gred Elementery/Secondery (0-12)	e completed) College (1-4or 5-		 Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) 		during most of word)	rking		0011000311101	uotry
2	77 12 14 191	Com	Elementary/Secondary (5-12)	4		Public	Rela	itions		National Guard Hdg		
pu	be filed tal Hygid d other	Be	17. Father's Nema (First, Middle, Last)						me (First, Middla, i		ne)	
ryla	should be and Mental marked or umatic eve	To	Samuel Leonard Ho						ne Graha			
, Maryland	C1 00 20 00		Beverly Smith (Si					end Number or Ru Frederi				Code)
Baltimore,	Pages 1 and ment of Health ant: If Item 27 ury or other 1		20e. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ R	lemovel from Stete	20b. Plece of cemeter	Disposition (i	Neme of or othar ple	се)	Date	20c. Location	City or Tow	vn, Stata
tim	tant:		4 Donetlon 5 □ Other (Specify)		Mount	Olivet	Ceme	etery	1/8/00	Frederi	.ck, M	laryland
Bal	permit. Pages Department of H Important: If ite any injury or of once.		21. Signature of Furneral Service License	2300 L	1	1201	MORTI	DAILEY & I MARKET	ST ERF	DERICK		
23a. Papt. Enter the disease, or complete stress that caused the offith. Do not enter the mode of dying, such that the part failure. List only one cause on each fine.							ng, such es cardiac	or raspiretory err	est,		Approximete Intarval Between Onset end Death	
7	/Medicai		Immediate Cause (Finel disease or condition	Pancre	atic Ca	ncer						1 yr.
В	Examiner		resulting in daath))	Due to (or es e o	onsequence	of):					
	ed sit	nlne),							i	
,	rificeta be axecuted ng physician and as the bunal-transit	Physician/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events		ue to (or es e c	onsequence o	of):					
68760,	ysicla he bur	cal	Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of):								-	
	E 0 8	Med	resulting in deeth) Lest		40 (0) 00 00	011004001100 0	,,,				1	
Вох	death cer e attendin ed for use	lan/		l							1	
	the all	/slc	Part II. Other significant conditions con	tributing to death but	not resulting in	the underlyin	g ceuse giv	en in Pert I.	23b. Did to	bacco usa co	ntribute to	the cause of death?
s, P.O.	s that the pned by the e detache	by Phy							1□ Y	88 2 No	3 Probe	ably 4 Unknown
Records,	law requires that the de as been signed by the 2 2 should be detached	Completed							24e. Wes e perform	n eutopsy ned?	eval	e eutopsy findings labla prior to plation of cause seth?
	0 - 0	mo:					+		1 P	s 2 No		Yas 2□ No
	ysician: The is cartificate director, pag	Bec	25. Wes cese raferred to medical					26. Plece of Dee	th (Check only on	e)		
of V	Physician: this cartific ral director,	2	exeminer? 1 Yes 2 No	ospitel: 1 🗆 Inpatien	2 X ER/Out	petient 3	DOA Oth	er: 4 🗆 Nursing H	ome 5 Reside	nce 6 Oth	er (Specify)	
ion	Attending PI ir death. ector: After th by the funera		27. Menper of Deeth 1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28a. Dete of Injury (Month, Dey		me of jury M	28c. Injur Wor					
=	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, fen (Specify)	ferm, street, factory, office 28f. Locat				tion (Street end Number or Rural Route Number, or Town, Stete)		
	To the Hospital of within 24 hours of To the Funeral D completely filled it	edical	29e. Certifier (Check only one) 1 CKCertifying Phys 2 Msdlcal Examin	ician: To the best of er: On the basis of e end manner stete	xaminetion and	deeth occurre /or Investigati	ed et the tir on, In my o	ne, dete end plece, pinion, deeth occur	, and due to the ce rred et the time, de	euse(s) end ma ete end place,	nner as sta and due to t	ted. he cause(s)
	Nithin Fo the	M	29b. Signet re and title of certifier	Committee state	-	2	29c. Licens	e number	2	9d. Dete signe	d (Month, De	ey, Year)
	> 0		Martin -	· Man	Q W)		D089	44		anuary		
			30. Neme and eddress of person who con Martin C. Shargel,	mpleted ceuse od	ith (Item 23a) (T Farragi	Type, Print)	nue,	Kensingto	on, Maryl	land 20	895-21	110
	Stat Registra		31. Dete filed (Month, Dey, Year) JAN 07 20	32. Registrer		B.	-	uls				

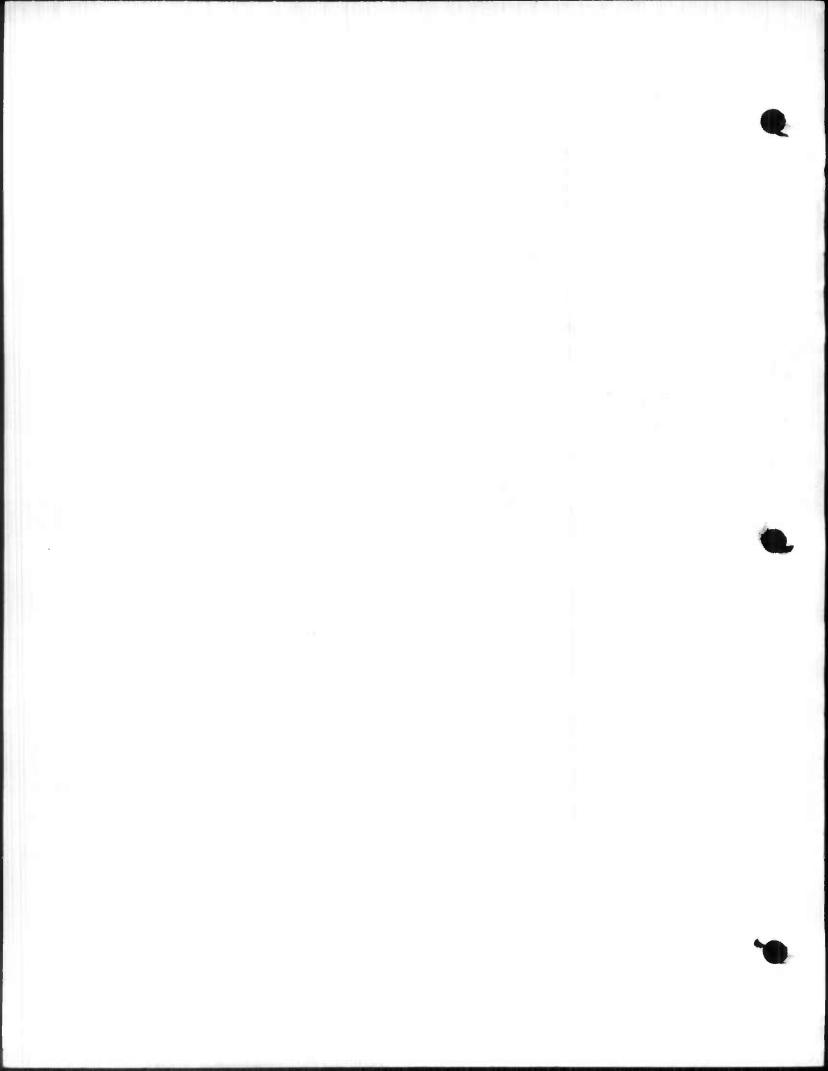
DHMH 16 Rev 6/95

Walte Halley

	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hose	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	WITH	plete	crem	remt,	l
)	uted	1 000	urial,	le en	
	900	In and	to bu	amat	
)	ate be	ysicia	prior	ta.	ľ
	artifica	ng ph	glene	othe	l
	th ce	tendir	al Hy	0	ı
,	he de	the at	Ment	Juny,	I
	that th	d by	and a	iny in	ı
	nires	signe	Health	WS 3	I
	v requ	been	t. of	sho	l
	ne fav	has	Dep	n 23	ŀ
	IN: I	ficate	State	Her	l
	SICIA	certi	h the	d, 0	
	3 PH	er this	th with	arke	ļ
	NDIN	R. Afte	r dea	is m	l
	ATTE	SCTOR	s afte	28	l
	L OR	DIRE	hour	Item	
	PITAL	ERAL	in 72	T: II	l
	HOS	FUN	with	M	
	뿔	품	pal	Ö	
	0	6	63	뮑	

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)		0.000	IGAIL OI	DEATH	2. DATE OF DEAT		3. TIME OF DEATH	н		
	Marguerite.	Theresa Kemp 6					_	YEAR 3:15	PM		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	н Т	BIRTHPLACE (State or Fore	reign		
	222-56-9274	1 □ M 2 ☑ F 8	2 YRS.	MONTHS DAYS	HOURS MIN.	August S		Delaware			
	9e. FACILITY NAME (If not institution, give str	reet end number)		9b. CITY, TOWN	OR LOCATION OF D			Y OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT	Center		Frede	rick			Frederick			
Ä	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY			
	Maryland Frede	erick	1 :	New Mark	et			LIMITS?	NO		
AL	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?			
FUNERAL	6451 Lakeridge Dı	rive			21774		Unit	ed States			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES				NIC ORIGIN? (Specif		4. RACE — American Indian	n,		
BY	1 Never Married 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Speci	en, Puerto Rican, ato ly:	-)	Black, White, etc.			
60	15. DECEDENT'S EDUC	ATION	14- 05050511710				1	White			
Ľ۱	(Specify only highest grade of	completed)		USUAL OCCUPATION FOR done during more method)		16b. KIND OI	F BUSINESS/INDU	STRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Superma	,	mlr.	D-h-	41 E 1				
COMPLET	17. FATHER'S NAME (First, Middle, Lest)		ouperma.	rker cre		ME (First, Middle, Me		Service			
	John Oat										
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street e		Rowalsk Route Number, City o		iorfel	_		
임	Norma Yeager / Dau	ighter						yland 21774			
	20a, METHOD OF DISPOSITION	200	PLACE AND DATE	F DISPOSITION (NE			LOCATION — CH				
	1 🗵 Buriel 2 🗌 Cremation 3 🗍 Remo	CON	etery, cremetory or of acelawn		1 Park			e, Delaware			
- 1	21. SIGNATURE OF FUNERAL SERVICE LICE	Deser A	1/	-	D ADDRESS OF FA	VOILTY Stan	ffor Fur	neral Homes,	TO A		
- 1	1. Dough	March	fer	1621 0	nossumto	wm Pika	Freder	ick, MD 2170	, FA		
_	23. PART I. Enter the diseases, or co	omplications that ćausec	I the death. Do n								
	snock, or neert failure. L	lst only one cause on e	ach line.	or ones the mo	de or dying, suc	as cardiec or t	eaphractory arres	it, Approximat Interval Bet Onset and I	tween		
	disease or condition ALZHEIMERS DEMENTIA										
	resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF):										
z											
은	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
<u>გ</u>	CAUSE (Disease or Injury										
٥	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	d.										
AL O	PART II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying	cause given in	Part I. 24s. WA	S AN AUTOPSY	24b. WERE AUTOPSY FINE	DINGS		
<u>ই</u> ∥						PEI	RFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAI	0		
EDIC						1 U YE	S 2 NO	OF DEATH?			
Σ	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S II NO E	UNCERTAI			1 TES 2 NO	0		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		OTTOLKIAN						
Sic		HOSPITAL: 1 Inpetient 2 ER/Outp	atient 3 DOA	OTHER:	a 5 🗆 Residence	6 Other (Specify)					
₹∥	27. MANNER OF DEATH	28s. DATE OF INJURY	28b, TIMI	OF 28c. INJ	URY AT	28d. DESCRIBE H	OW INJURY OCCUI	RED			
> 1	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJI	M 1 1	RK? 'ES 2 NO						
ED B	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	treet, factory, offic		281. LOCATION (St	181. LOCATION (Street and Number or Rural Route Number,				
	4 Homicide determined					City or Town, S	rate)				
7	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edge, death occurre	d at the time, date	end place, end due	to the cause(s) and	manner as stated.				
COMPLE		On the basis of examination							ted.		
20h SIGNATIIRE AND TITLE OF CERTIFIED								BIGNED (Month, Day, Year)			
<u>۵</u> ∥	Mil Warm	mo			0471		N	uncy 1, 2000			
2	30. NAME AND ADDRESS OF PERSON WHO		ATH (ITEM 27) (Type,						_		
	NEIL WARANDRIVAN		mary A	12 # 51	04 Frus	RAPMICK	MD 21	702.			
	JAN 03 2000	32. REGISTRAR'S SIGN	ATURE 6	1							
l l	JAN U 3 ZUUL	1	10.	ppa	6						





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Mary Rebecca KELLER January 4th 2000 12:20 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Hospital Center Hagerstown Washington If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Days Hours Months 1□M 2♥F 218-50-3893 Maryland Oct. 21 1946 Usual Residence of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2X No Maryland | Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 17601 Taylors Landing Road 21782 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Nevar Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Her own home 18 Mother's Name (First Middle Maiden Sumame) 17 Father's Name (First Middle Last) Gerald A. Keller Eleanor J. Shinham 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17601 Taylors Landing Rd. Sharpsburg, Md. 21782 Gerald A. Keller - Father 20b. Place of Disposition (Name of cometery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/7/2000 Hagerstown, Maryland Rose Hill Cemetery 21. Signature of Funaral Service Licensee 22 North and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Acute Myocardial Infarction 5 Minutes Due to (or as a consequence of): Pneumonia 3 Days Due to (or as a consequence of): Multiple Scerosis Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed?

Physician /Medical Examiner Examiner

physician and s the buriel-transit

80

080 0 ed by the detached

signed by t d be detact

Deed page 2

this After this

To the Hospital or Attanding within 24 hours effect death. To the Funeral Director: Afte completely filled in by the fun.

edical

Physician/M

à

Completed

8

To

Certification:

Medical

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

or Attanding

permit. Peges 1 and 2 a Department of Health or Important: If ham 27 le eny injury or other trau

Physician

/Medical

Examiner

10a. State

Funeral

Director

Nema 23a or 28a-f ahow ther must be notified at

Director

À

Completed

the Maryland

with

death

Peges 1 and 2 should be filled within 72 hours after nant of Health and Mentel Hyglans. nt: If ham 27 le marked other than "natural", or he

traumatic event,

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

art I	II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert
9	Stroke

1 Yes 2√ No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medicat examiner? 26. Placa of Deeth (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Placa of tnjury - At home, farm, atreet, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

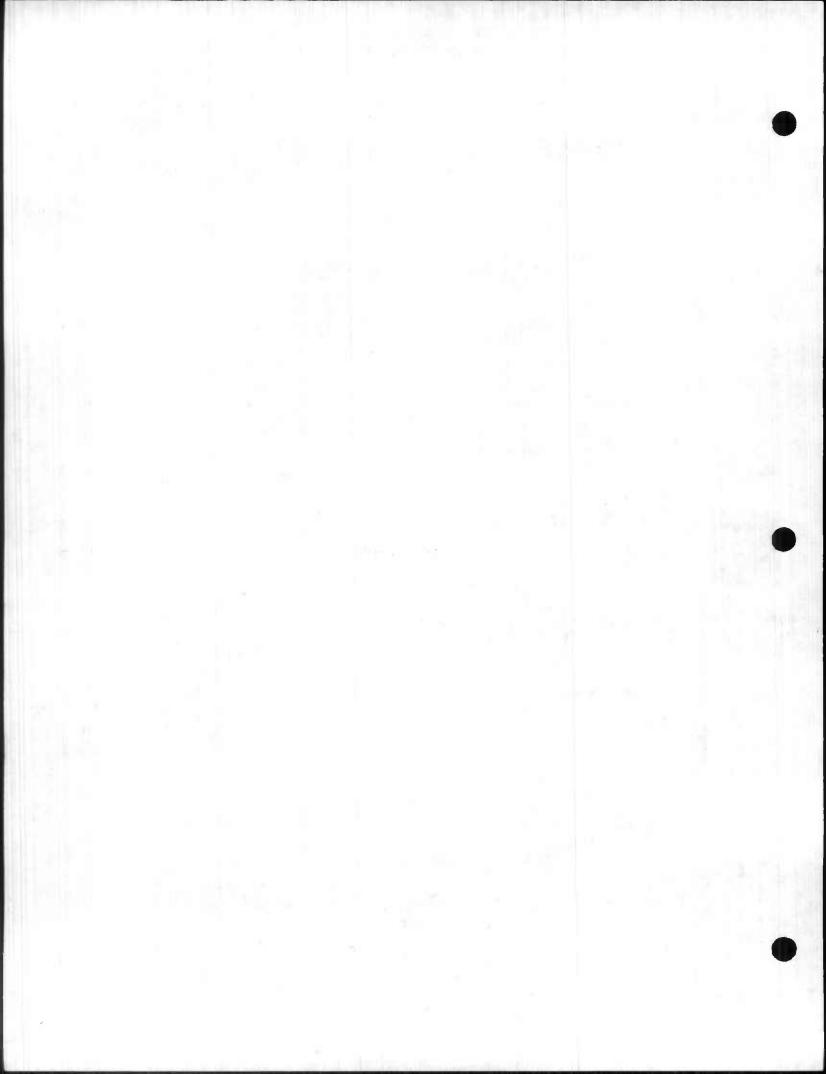
D41112 January 4, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Western Maryland Hospital Center

State Registrar

Tan H. Newbold, M.D. 31. Dete filed (Month, Day, Year) JAN 06 2000

32. Registrar's Signature Dener

1500 Pennsylvania Avenue, Hagerstown, Maryland oaks.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 1, 2000 4:22 a.m. James Andrew Kerns /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Carrol1 Westminster Months Days Hours Min. April 27, 1928 Birthplace (State or Foreign Country)
 W 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F 218 24 9282 Yrs. 71 Director Usual Residence of Dacedent the Maryland 10a. Stele 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f show Examiner count be notified at PA Franklin Waynesboro X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 West Eighth Street 17268 U.S.A. death v Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "netural", or heavy injury or other traumatic event 1 Never Merried 2 Married 1 KOYas 2 □ No If Yes, Give Yeer or Detes: WWII 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Chemist Aircraft 5+ 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be John Winfred Kerns Grace Pear1 Hovermale 20 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine L. Kerns 226 West Eighth Street, Waynesboro, PA 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1XXBurial 2 □ Crametion 3 □ Removel from Steta Friendship Cemetery Jan. 4, 2000 Berkeley Springs, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. ature of Funeral Service Licensee M00522 306 Union St., Berkeley Springs, WV 25411 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical immediate Cause (Finel VENTRICULAR diseesa or condition resulting in death) Examiner MYOCARDIAZ INFARCTION Physician/Medical Examiner ACUTE that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseesa or injury that initieted events rasulting in death) Lest P.O. Box 68760. Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco usa contribute to the cause of death? been signed by should be detact 1 Yes 2 Probably 4 Unknown Records. þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 400 1 Yes 2 No of Vital Hospital or Attending Physician: director Be 25. Wes case raterred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 I I patient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To this 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Meturel 5 Pending 1 Yes 2 No 24 hours after deeth. invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

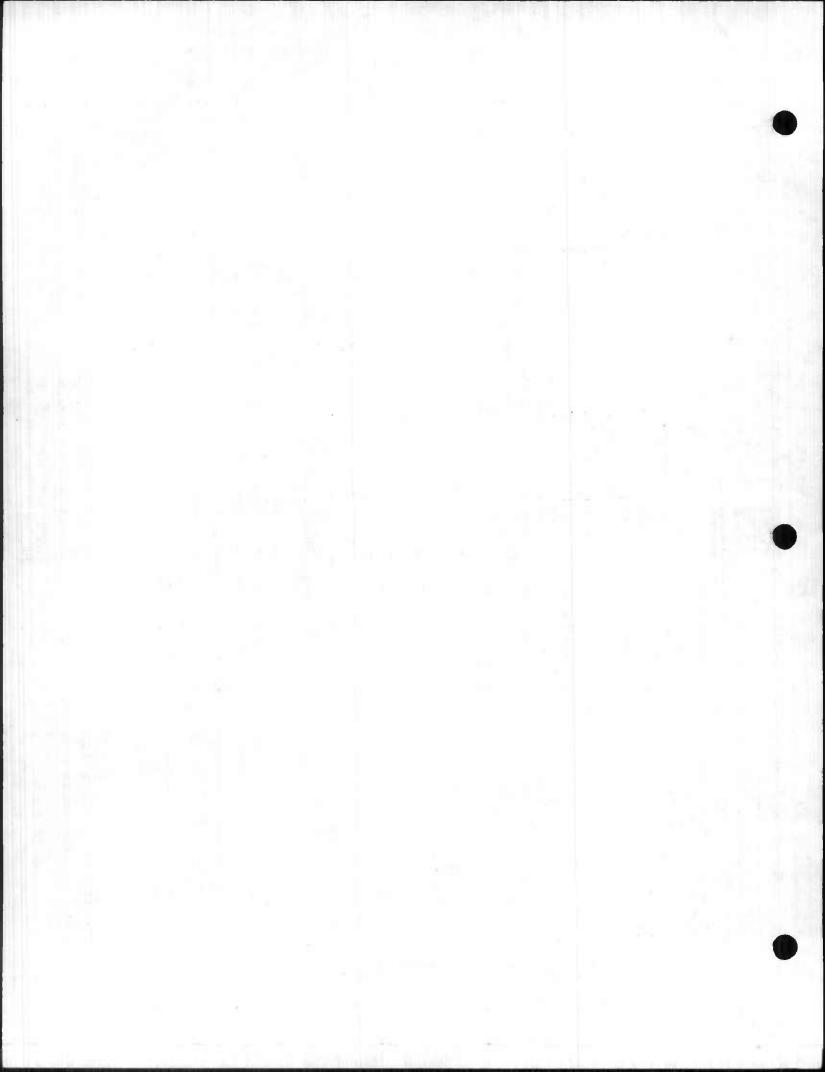
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) within 2 the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Warenway D18200 1-1-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE Rd CNESTMINSTER
CHIT RACHEDY NAGANNAMD 700 A POOLE Rd CNESTMINSTER JAN 0 5 2000

DHMH 16 Ray 6/95

State Registrar

31. Dete tiled (Month

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () () | 2 | 8 · Certificate of Death

			,		Certifica	te of D		F	leg. No.		16.10		
		1. Decedent's Nama (First, Middle, L.	ast)					2. Data of Dea Month	th Dev	Year	3. Tima of Death		
	Physician /Medical	Rev. Vincent J.	Kowalewski,	Jr.,	O.S.F.S	S .		Januar			0952		
	Examiner	4e Fecility Neme (If not institution, gi	ive street and number)			4b	City, Town, or	Location of Death					
		Union Hospital				- 6	Elkt		-	ecil			
	Funeral		150 M 00 E	yrs. last birti	Months	er 1 Year Days	If Undar 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day	Birth 9. Birthplace (Stata or Foreign Country)				
	Director	221-12-9625	7	6 '	rs.			November	15, 19	23 De	laware		
	2 8	Usual Rasidence of Decedant 10a. Stata 10b. County	10	c. City, Town	or Location					104	. Inside City Limits		
	show ed.at			•	lds					100.	1 ☐ Yas 2 No		
	vith the Maryland to or 28a-f show be notified at Director	7	**	CIII					70.00				
	5 a 4 W	10e. Sireel and Number 1120 Blue Ball	Road		101. 2	ip Code 219	16		Og. Citizen of V United				
Maryland 21215-0020	Eran by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Evar Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Dates:	in U,S.	If Yas, sp	edenI of His ecify Cuben 2IXNo	, Maxican, Puart	pecify Yas or No- o Rican, atc.)		a - Amarican k, Whita, atc Whit			
20	od within 72 ho typiene. wer than "naturn it, the Medical.] Completed	15. Decadent's E	ducation	16a.	Decedant's Us	ual Occupat	ion uring most of wo	ting	16b. Kind of Bu	isinass/Indus	itry		
21	to Med	(Specify only highast gr Elementary/Secondary (0-12)	Collega (1-4or 5+)	-	life. DO NOT	use retired)	iring most or wor	King					
2	the piece		4+		Pries	t/Teac	her		Reli	gion			
Pu	tal Hyginal district and other avent. I	17. Fathar's Nama (First, Middla, Las	1)				18. Mothar's Ner	na (First, Middle,	Maiden Sumam	a)			
/la	Mental H Mental H arked oth aftic aven To Be	Vincent J. Kowa	lewski, Sr.				Joze	fa Grabo	wski				
an)	ods and	19a. Informant's Name/Ralationship	(Type, Print)	19b.	Mailing Addra	ss (Street ar	nd Number or Ru	ırai Routa Numbe	r, City or Town,	Stata, Zip Co	ode)		
	27.1	Rev. Francis J.	Hanlon, O.S.	F.S. 2	2200 Ke	ntmere	Parkwa	y, Wilmi	ngton,	Delawa	re 19806		
Baltimore,	Pages 1 a tent of Heam nt: If hem nry or othe	20a. Method of Disposition 1 X Buriel 2 Cremetion 3	2	Ob. Plece of	Disposition (Ny, crematory or	ama of othar place)	Dete 1/7/00	20c. Location -	City or Town	n, Stata		
÷	Part Part	4 Donation 5 Other (Speci	• •	Oblat				1///00	CIIIIGS	, mary	Lana		
Bal	Departiment important	21. Signatura of Funaral Sarvice Lice	O Ll		Hicks		for Fun	erals, F		J 3 (21021		
		23a. Part1. Enler the disease, or con	nplications that causad tha	daath. Do n				or raspiratory ar			21921 pproximata		
4	Physician	shock, or haart failura. List only	ona cause on each lina.								itarval Batween		
	/Medical	Immediata Causa (Finel											
	Examiner	disaasa or condition resulting in death)	a. Myocardi										
	ē				onsequence of):				ı			
	ficate be executed physician and s the burial-transit edical Examiner		Diabetes	Melli	itus					<u> </u>			
	tificate be executed g physician and as the burial-transit fedical Examir	Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated evants Due to (or as a consequence of): Due to (or as a consequence of):											
09	be e ician buris	cause. Enter Undarlying Cause (Disease or injury	C								100		
68760,	cate the the	resulting in daath) Last	Due	to (or as a co	onsequance of):							
	5 0 0		d										
Вох	death cert e attendin ed for use siciar/N		•										
	0 0 0	Part II. Other algnificant conditions	contributing to death but no	t rasulting in	tha underlying	causa giver	n in Pert I.	23b. Dld t	obacco use co	ntribute to th	ne cause of death?		
<u>P</u> .	requires that the death cereon signed by the attendin hould be detached for use ated by Physician/N	Diabetes Mellit	-115					101	'es 2□ No	3 Probat	bly 4 Unknown		
Ś	by be	22000000											
Vital Records,	The law require cate has been single 2 should Completed	Colon Cancer						24a. Was perfor		availe	autopsy findings able prior to		
CO										of dea	eth?		
Œ	The hard							1 D Y	as 2 XNo	1 🗆 Y	ras 2□ No		
<u>e</u>	sician: The law certificate has b lirector, page 2 s	25. Was case rafarred to medical					26 Place of Dec	eth (Check only o		1			
	Physician: r this certification and director, r: To Be (axamiwer? 1 ☑ Yas 2 ☐ No	Hospitel: 1 Inpatiant	2 TER/Out	patient 3 0	Other		loma 5 ☐ Rasid		ar (Specify)			
0	5 5 5	27. Manner of Death	28a. Data of Injury (Month, Day Yea		ima of	28c. Injury		28d. Describe h					
0	th. the fun	1 Netural 5 Pending 2 Accidant investigation		ar) In	jury M		as 2 No						
Division of	dea ctor	3 ☐ Suicide 6 ☐ Could not t		At home, fan	m, street, fecto	ry, offica		28f. Location (S	treet and Numb	er or Rural R	loute Number,		
Š	tal or Attending P rs after death. al Director: After t led in by the funer Certification:	4 Homicida	building, atc. (S)	pecify)				City or Tow	n, Stata)				
	To the Hospital or Attending Philipping 24 hours after death to the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical Example of the Check on the Check on the Check on the Check on the Check of the Check on the Check of the Check on the Check of the Check	hysician: To the best of my miner: On the basis of axa										
	thin 2 the it	one)	and mannar stated.										
	or or or	29b. Signatura and titla of certifiar	00 0		2	9c. Licansa	number		29d. Dala signe	7			
		Mill	The enla	_)-5	2087	7	Jenvar	1 3	2000		
		30. Nama and addrass of person who								0)			
		Michael J. Pia:	rulli, M.D.,	106 B	ow Stre	et, E	lkton, 1	Maryland	21921				
	State	31. Dete filed (Month, Day, Year)	32. Registrar's S	Signature	,	1					1-10-11-12		
	Registrar	IAN 0 5	2000 1 /2e	war	19	hoor	Kal						

DHMH 16 Rev 6/95

11 h

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month ROBERT 2000 JAN 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ITER HAGERS TOWN WESTERN MARYLAND HOSPITAL CENTER WASHINGTON Sociei Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 212-24-2163 M 2□ F Deys Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits Allegany 1 Yes 2 No Barton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19201 German St. 21521 United States 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 Never Married & Married types 2. No if Yes, Give— Year or Dates: Korea 1 ☐ Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coliege (1-4or 5+) U.S. Government Mechanical Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Robert K. Kelley, Sr. Bessie Boal 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Roberta Cook / Daughter 21404 McMullen Highway Rawlings, MD 21557 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland Crematory 1/7/00 Cumberland, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility 111 Church St. 7. Win Westernport, MD 21562 Boal Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory errest shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Fine RENAL FAILURE 2 WEEK4 disease or condition resulting in death) Due to (or es e consequence of): HEART FAILURE MONTH'S Due to (or es e consequence of) YEARS DIABETES Due to (or as a consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No VENT-DEPEMBENT 24b. Were eutopsy findings evalleble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 1 No 1 Yes 2 No 26. Plece of Deeth (Check only one)

Physiclan /Medical **Examiner**

pue

physicien

signed t

pege 2 s

certificate

After

Director: /

To the Hospital within 24 hours or To the Funeral Completely filled

Hospital or Attending Physician: 24 hours efter death,

the

Exam

Physician/Medical

2

Be Completed

Certification: To

Medicai

certificate be executed

Box 68760,

P.O.

Records,

Vital

of

Division

Physician

/Medicai

Examiner

10a State

Md

Funeral

Director

28a-f show must be notified at

6

Items 23a

ŏ

"natural",

Hygiene.

permit. Peges 1 and 2 should be filled with Department of Health and Mental Hygiene Important: If flem 27 is marked other that any furry or other traumatic avent, It at 0000.

Director

Funerai

þ

Completed

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

REJPIRATORY FAILURE

25.	Wes case of exeminer? 1 ☐ Yes		to	medica	t
22	Manne	De alla	-		

28e. Date of Injury (Month, Dey Yeer)

1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Neturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homicide

11 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted, 2 Medicet Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

nus

6

State Registrar

1500 PENNSYLVANIA AVENUE, HAGERSTOWN 21742 NEWBOLD, 32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00	0	1	0	2	0
00	0		6	6-	(

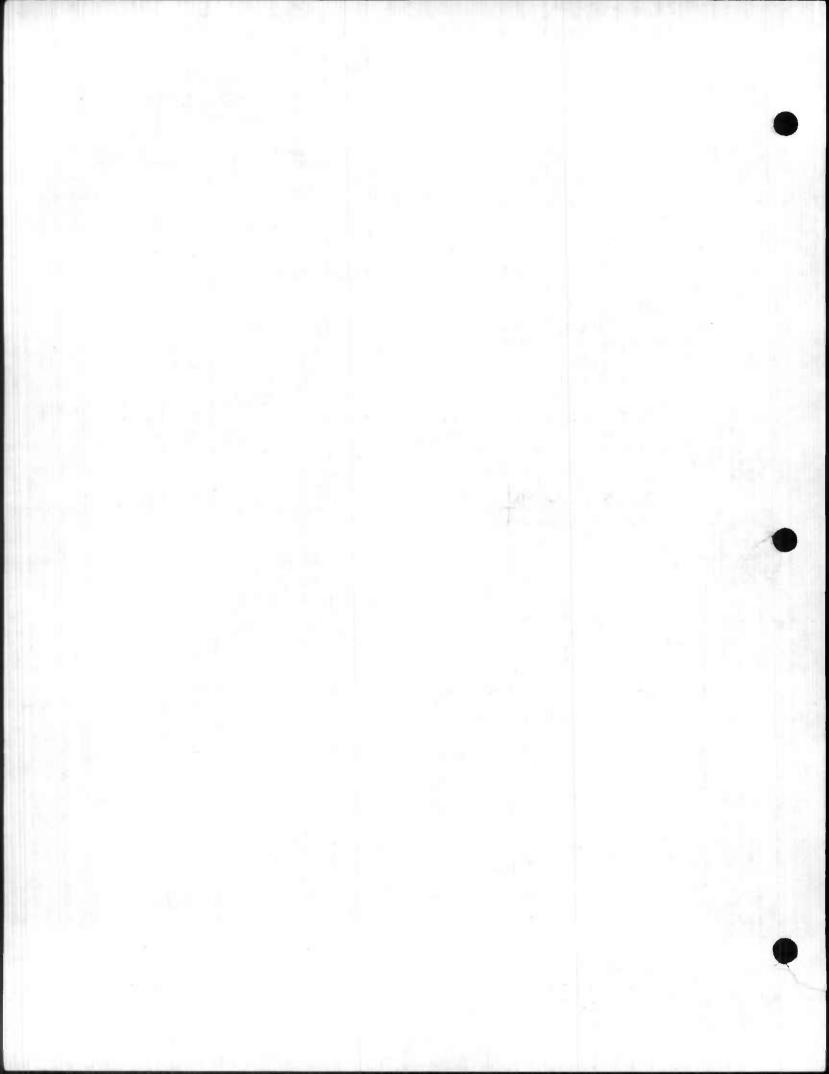
						Ce	rtificate o	f Death			Reg. No.		
			1. Decedent's Nama (First, Middle	ia, Last)						2. Date of Dec	ath		3. Tima of Death
ŧ.	Physic		KATHRYN GER	ALDINE KNO	TTS					Month Janua			
	/Medi		4a Facility Nama (If not institution					4b. City, To	wn, or Lo	cation of Death			1:15 pm
	Examii	ner		The state of the s	-/			0 1			Alle		
-			Memorial Hosp 5. Social Security Number		Age (In yrs. la	et hirthday)	If Under 1 Ya	Cumber of If Under	r Land 24 Hrs.	R Data of Birt		0 0	placa (Stata or Foraign
	Funeral		233-48-6085	1□M 2KDF	69	Yrs.	Months Day		Min.	8. Dafa of Birt (Month, De		Cour	ntry)
Ш	Director		Usual Residence of Decedant		09					Oct. 2	1,1930	west	Virginia
	bug *		10a. Stata 10b. County		10c. City,	Town or Lo	ocation					1	IOd. Inside City Limits
	Aary ah	5	WV Min	eral		Varia						- 1	1 X Yes 2 □ No
	1 8 B	Director	10e. Street and Number	erar		Keyse	10f. Zip Code			1	10g. Citizen of	What Cou	ntn/2
	5 6												nu y r
	72 hours after death with the Maryland natural, or Nems 23s or 28s-f show deal Examiner must be notified at	Funeral	132 Mozelle				267		1.0.40	W M		USA	and the first
	ar de	ů	11. Maritel Stefus	12. Was Decede Armed Force	as?	. 13.	Was Decedent of If Yas, specify C	ır Hispanic Ori uban, Mexicai	gin? (Spe n, Puarto I	Rican, atc.)	Bla	ce - Americ ick, Whita,	
20	or aft	by F	1 Never Married 2 Man	If Yas, Giva			1□Yas 2⊠N	lo Specity:			Specif	y:	
00	Jen J	q p	3 X Widowed 4 □ Divorced		is:					-		Whit	
21215-0020	n 72 hours aft "natural", or	Completed		it's Education st grade completed)		(Giva	dent's Usual Occ kind of work do	ne during mos	t of workii	ng	16b. Kind of B	usiness/In	dustry
12	filed within Hygiene. ther than	d E	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use ret	irea)					
2	Hygie ther t		8	1		Hot	nemaker	I del salis	4. 11	4000 0 40 4 40 4		wn Ho	ome
Ĕ	tal Hys d othe avent,	Be	17. Father's Name (First, Middle,	· ·							Maiden Sumar	ria)	
Maryland	2 should be and Mental is marked of sumatic ave	ပ	Howard R. Ch						-	. Faith	-		
Jar	C -0 -0		19a. tnformant's Name/Ratations			19b. Maiti	ng Addrass (Stre	et and Numb	er or Aura	I Route Numbe	er, City or Town	, Stata, Zip	Coda)
	5 = 7 ±		Barbara L. Whe	tze1/Daught			4, Box	114-A	. K	eyser,		726	
ore	8 5 5 0		20a. Mathod of Disposition 1 Burial 2 □ Cremation	2 Damousl from St	000		osition (Nama of matory or other p	olace)	Т	an. 6	20c. Location	- City or To	own, State
E	Pages nent of I int: If its		4 Donetion 5 Other (S			omac l	Memoria]	Garde			Keyser	. WV	
Baitimore,	permit. Page Department of Important: If any Injury or page.		21. Signature of Funaral Sarvice	Licensee		- 1	2. Nama and Ad			000			
m	SOFE		Brigar	· L Susti	9		Smith F						
			23a. Part1. Enter tha diseese, or	complications that cau	sed tha death.	Do not ent	85 S. Mar tha moda of o				er, WV	2672	Approximate
4	Dhysisian		shock, or heart feitura. List	only ona cause on aac	h lina.							1	Interval Batween Onset and Death
	Physician /Medical		tmmediate Cause (Finat				0 0					i	10.1205
	Examiner		disaasa or condition rasulting in death)	a	ODER	KSAC	POL	EOST		SEAS	\$5	1	TUYEARS
п		5			Dua to (or	as a conse	quence of):					i	
	ped nsit	Examiner		b								i	
	and and	xa	Sequentially list conditions, if any, leeding to immadiata		Due to (or	as a consec	quence of):					1	
68760,	the deeth certificate be executed by the attending physician and sched for use as the burial-transit	ale	Sequenfially list conditions, if any, leeding to immadiata cause. Entar Undarlying Causa (Disaase or Injury	c								1	
87	phys the	edicai	that initiated events rasulting in death) Last		Due to (or	as a consec	juenca of):						
×	ding entiti	2 1		d.								1	
Box	attendia	lan										1	
0	that the de ned by the a detached t	Physiclan/	Part tt. Other eignificant condition	one contributing to deat	h but not rasul	ting In tha u	ndarlying causa	givan in Part	t.	23b. Did	tobacco uee co	ontribute t	o the cause of death?
Θ.	d by		(chice with	= HE DO	I FA	rile	02			10	Y00 28 No	3 Pro	bably 4 Unknow
Ś	2 6 8	by	CONTRACTOR OF THE PARTY OF THE	711		110			_			T	
Records,	been s	ted	Warns	170H	TIS					24e. Wes	en autopsy rmed?	av	are autopsy findings vailable prior to
ecc	2 s L	Completed	O Proges									of	ompletion of causa death?
	0 - 0	E	Lala da	== 160V	20	12	2000			10	Yes 2 No	11	□Yas 2□ No
of Vital	delan: The	Bec	25. Was casa rafarred to medica	1 100	, 41		CETIC	26. Place	a of Death	(Check only o	ona)		
5		ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Ing	atient 2XF	R/Outpaties	nt 3 DOA	Other:			dence 6 Ott	her (Speci	fu)
	r this		27. Manner of Death	28a. Data of	Injury :	28b. Tima o		njury at Vork?			how injury occu		.,,,
O	ding Ih. After fune	tion	Natural 5 Pandir	'9	Day Year)	Injury		Vork? ☐ Yes 2☐	No				
S	or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could	not be 280 Bloom of	Injury - At hon	na. farm. st	reef, factory, office	ce	1	28f. Location (Street and Num	ber or Run	al Route Number,
Division	aftar Direction of a	Certification:	4 ☐ Hornicide determ	building	, alc. (Specity)		,,			City or To	wn, Stata)		
	Pres Pers		29a. Certifier 1X Certifyin	g Physician: To the h	set of my know	ladae desti	h cocurred at the	time data ar	d place o	and due to the	cauca(c) and m	1 20 10000	etated
	Hos 24 h Fun Fun	edical		Examiner: On the basi and menna	s of examineting								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	¥ E	29b. Signatura and title of certifia		VIEIGO.	2	29c Lin	ense number			29d. Dafa signe	ed (Month	Dev. Year)
	1	/		Land	, Ha	1		210-	7				
	(0		10000 LL		/	V.	ZK	10		Januar	cy 4,	2000
	Ja.		30. Nema end eddress of person										
	n	8	Dr. Robert Weli				ite 308	, Cumbe	rlan	d, MD	21502		
	Sta		31. Data filed (Month, Dey, Year)		istrar's Signetu	Ira 4	1000	,					
	Registi	ar	JAN 1 0 20	UU 24		N	QUOLES						

The property of agreement

Piease Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 122

			Certifica	te of	Death		Re	g. No.			
						2	2. Date of Death			3. Time of Death	
		tterman	Sr		a					1:34 PM	
Frederick M	Memorial Ho				Frede	erick	ick Frederick				
216-38-0734	Sex 7. Ag		Month		Hours		Month, Day,	, 1941	9 Birthpl Count Mary	ace (Stete or Foreign and	
10a. State 10b. County	rick			T					10	Od. Inside City Limits	
10e. Street and Number 214 East patri	ck Street,	Apt. 2					U.S.A.				
11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?		It Yes, sp	ecity Cub	lispanic Ori an, Mexican Specify:	gin? (Spec), Puerto Ri	ity Yes or No- can, etc.)	Ble	ck, White, e	etc.	
		16a.	(Give kind of v	rork done	during mos	t of working	, 1	16b. Kind of B	usiness/Ind	ustry	
Elementery/Secondary (0-12)	College (1-4or	5+) Se					_ 1	Board (of Edu	ucation	
		man						faiden Sumer	For	i	
	f. Maria		. Mailing Addre	ss (Street awill	and Numbel	or or Aural	Route Number, Charles	Town,	W. Va	Code) 25414	
		20b. Plece of cemeter Mount	Disposition (N x.crematory of LIVEL (A	ame of other pla meter	ce) y	Jan.					
21. Signeture of Funeral Service Lice		100255	Keene	y an	d Bas	ford				1701	
Immediate Cause (Finel disease or condition resulting in death)	a. <u>A</u>	THE SECTION AND ADDRESS OF THE SECTION ADDRESS OF THE S			MSCULA	R DIS	ભકર			zzlus	
Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury											
that initiated events resulting in death) Last											
Part II. Other elemificant conditions	annelle die de deuth h	and much manufacture in	About contain the fire		on in David						
		ut not resulting in	i me underlying	cause gn	ven in Pist i			_		ably 4 Unknow	
D	EMENTIA								con	re autopsy tindings iliable prior to npletion of cause leath?	
							1□ Ye	s 2 0 No	1□	Yes 2□ No	
25. Was case referred to medical axaminer?	Hospitel:	~		Ott	hor						
27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju		ime of	28c. Inju	ry at	28				")	
3 ☐ Suicide 6 ☐ Could not	28e. Plece of Inj	ury - At home, te c. (Specify)					f. Location (Str City or Town	reet and Num , State)	ber or Rura	l Route Number,	
29a. Certifier (Check only one) 18 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o and menner st	of my knowledge examination and eted.	, deeth occurre d/or Investigation	d at the tie	me, date an opinion, dea	d place, en th occurred	d due to the ca l at the time, da	use(s) and m	enner as st and due to	ated. the cause(s)	
29b. Signeture end title of control	1						25		ed (Month, L	Day, Year)	
	Larry 4a Facility Name (If not institution, g Frederick M 5. Social Security Number 216-38-0734 Usual Residence of Decedent 10a. State 10b. County Maryland 10c. Street and Number 214 East patri 11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced (Specify only highest g Elementery/Secondary (0-12) 17. Father's Neme (First, Middle, Last 19e. Intorment's Neme/Reletionship Mr. Gregory W. K 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spec 21. Signeture of Funeral Service Lice 10 Sequentially list conditions, if any, leading to immediate Cause, or heart tellure. List only 10 Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other significant conditions 1 Suicide 1 Security of Could not determined the Cause (Finel disease) 2 Accident 3 Suicide 6 Could not determined the Could not determined	4a Facility Name (If not institution, give street and number) Frederick Memorial Ho 5. Social Security Number 216-38-0734 Usual Residence of Decedent 10a. State 10b. County Maryland Frederick 10c. Street and Number 214 East patrick Street, 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Spondary (0-12) College (1-4or street) 17. Father's Neme (First, Middle, Last) Ira Arthur Ketter 19e. Informent's Neme/Relationship (Type, Print) Mr. Gregory W. Ketterman, 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service License 1 Sequentially list conditions, if any, leading to immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Spease or injury that initiated events resulting in death) Last 25. Was case referred to medical axaminer? 1 Yes 20 No 27. Manner of Death 1 Neutral Status Conditions contributing to death be the determined of the provided of the provided of the conditions of the cause (Finel disease or injury that initiated events resulting in death) Last 26. Was case referred to medical axaminer? 1 Yes 20 No 27. Manner of Death 28a. Dete of Injury that initiated events of Check only one state of the determined of the provided of the determined of the provided of the provided of the determined of the provided of the provided of the determined of the provided of the pro	Larry Raymond Ketterman 4s Facility Name (if not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 216—38—0734 Usual Residence of Decedent 10s. State 10b. County Maryland Frederick 10c. City, Tow Maryland Frederick 5treet, Apt. 2 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12 College (1-4or 5+) 17. Father's Neme (First, Middle, Last) Ira Arthur Ketterman 19e. Informent's Neme/Reletionship (Type, Print) Mr. Gregory W. Ketterman, Sr., 66 20e. Maghod of Disposition 1 Disurial 2 Cremetion 3 Demovel from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service License) M00255 23a. Pert. Enter the disease, or complications that caused the deeth. Dor shock, or heart teiture. List only one cause on each line. Sequentially list conditions, if any, leading to immediate Cause. Enter thederiving Cause, City Hoderlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition 1 Due to (or es a cause. Enter Underlying Cause, Disposition Cause,	Larry Raymond Ketterman Sr 4s Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 216-38-0734 6. Sax 216-38-0734 7. Age (In yrs. last birthday) Months 216-38-0734 10a. City, Town or Location Frederick 10b. County Maryland Frederick 10c. City, Town or Location Frederick 10c. Street and Number 214 East patrick Street, Apt. 2 21. Merital Stetus 11 Never Merried 3 Widowed 4 Divorced 11 Never Merried 3 Widowed 4 Divorced 12 Wes Decedent Ever in U.S. Armed Forgas? 11 Yes, Spin 12 Wes Decedent Ever in U.S. Armed Forgas? 13 Wes Decedent Ever in U.S. Armed Forgas? 11 Yes, Spin 12 Yes, Spin 13 Wes Decedent Ever in U.S. Armed Forgas? 11 Yes, Spin 12 Yes, Spin 12 Yes, Spin 13 Wes Decedent Ever in U.S. Armed Forgas? 13 Wes Decedent Ever in U.S. Armed Forgas? 11 Yes, Spin 12 Yes, Spin 12 Yes, Spin 13 Wes Decedent Ever in U.S. 14 Department Proceeding Spin 15 West Decedent Ever in U.S. 16 Decedent Spin 17 Yes, Spin 17 Yes, Spin 18 Yes, Spin 18 Yes, Spin 19 Wes, Spin 19 W	Larry Raymond Ketterman Sr 4s Facility Name (**It not institution, give street and number)* Frederick Memorial Hospital 5. Social Security Number 216-38-0734 **Top 10. Supplementary 10. City, Town or Location Frederick 10e. Street and Number 214 East patrick Street, Apt. 2 11. Merital Stetus 11. Merital Stetus 12. Wes Decedent Ever in U.S. 13. Wes Decedent Ever in U.S. 14. Merital Stetus 12. Wes Decedent Ever in U.S. 15. Decedent's Education (Specify only highest grade completed) 16e. Street Stre	Larry Raymond Ketterman Sr 4a Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 216-38-0734 5. Social Security Number 217- Age (in yrs. last birthday) 100. Caty, Town or Location Frederick 100. Street and Number 217- East patrick Street, Apt. 2 217-01 11. Merital Status 12. Was Depodent Ever in U.S. 11. Merital Status 11. New Beadest of Hispacic Offer Armer Forger 11. Yes, Give 11. Yes, Socially Cuber, Meritan 12. Social Security Cuber, Meritan 13. Merital Status 14. Social Security Cuber, Meritan 15. Institute Deposition 15. Social Security Cuber, Meritan 16. Decedent's Usual Occupation 16. Decedent's Usual Occupation 17. Father's Name (First, Micklist, Last) 18. Malling Address (Street and Number Armer Control of Cont	Larry Raymond Ketterman Sr 4s Facility Name (if not institution, give street and number) 4s Cay, Town, or Lock Frederick Memorial Hospital 5s Social Security Number 216-38-0734 \$\times \text{XM} \text{ 2 F} \text{ 7. Age (in yrs. last birthday)} Hunder 17 Year Hunder 24 Hr. 1. 10s. Caty 10s.	1. Decedent's Name (Frier, Michic, Last)	Larry Raymond Ketterman Sr de Facility Name (find institution, pive steet and number) Frederick Memorial Hospital S. Social Security Number 216–38–0734 David Part Roymond Force 217–218–218–218 David Part Roymond Force 100. Cety, Town or Location Frederick Frederick To Cody 100. Cety Town or Location Frederick David Part Roymond Force 100. Cety Town or Location Frederick 100. Cety Town or Location In	1. Deceded to Name First, Michiel, Latty Larry Raymond Ketterman Sr 4a Facility Name (fine) institution, give sinest and number) Frederick Memorial Hospital 5. Social Security Number 1. Social Security Num	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month January 3, 2000 Julia May Lynch 1427 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Chestertown Nursing and Rehabilation Center Chestertown Kent if Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 102 Yrs. If Under 1 Year Months Days 5. Sociel Security Number Birthplace (State or Foreign Country) Year) 1 M 20 F 216-12-1831 February 28, 1898 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Morgnec Road 21620 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White ¾XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker domestic / own home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Hart Simpkin Queen Victoria Baxter 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip 0909)410 19a. Informant's Name/Relationship (Type, Print) 3712 Rock Haven Drive, Greensboro, North Carolina Calvin W. Lynch - son 20b. Place of Disposition (Neme of cemetery, crematory or other place) January 5, 2000 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) St. Paul's Cemetery Chestertown, Maryland 21. Signature of Fun 22. Name and Address of Facility William L. King Jr. M-00937 Fellows, Helfenbein & Newnam Funeral Home P.A.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

Approximate Immediata Cause (Final Cardio Respiratory Arrest 12 hours disease or condition resulting in death) Due to (or as a consequenca of): Artero Sclevetic Cartio Vascular Diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as e consequence of): Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 2 No 1 Yes 2 No 28. Place of Death (Check only one) Other: AQ Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending

The law requires that the death certificate be executed physician end the burial-transit Division of Vital Records, P.O. Box 68760, 88 signed by the e Hospital or Attending Physician:

after deeth Director:

24 hours

To the Hosp within 24 ho To the Fune completely f

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

"natural", or items 23s or edical Exeminer must be

Peges 1 and 2 should be filed within 72 hours after death vest of Health end Mental Hygiene.

11. If flean 27 is marked other than "natural", or flems 23 my or other traumatic event, the Media Estatistics many or other traumatic event, the Media Estatists many.

permit. Peges Department of Important: If it eny injury or o

Physician /Medical

Examiner

Examiner

Physician/Medical

py

Completed

9

Certification:

Medical

Baltimore, Maryland 21215-0020

Directo

Funeral

p

Completed

with the Meryland

Atrialfibriliation, HxCHF., MxHTD, Hx Prenumen. Ha Condidal Phennonis, Hx Hipfx. & Radial fx.

Mchol., Hx Masteday, Kx Cdon Ct, Daneutia. 25. Was case referred to medical examiner?

1 Yes 2 No 27. Menner of Deeth

1 Naturai investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Yes 2 No 28e. Piaca of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number D50996

29d. Date signed (Month, Day, Year) Jan. 3, 2000

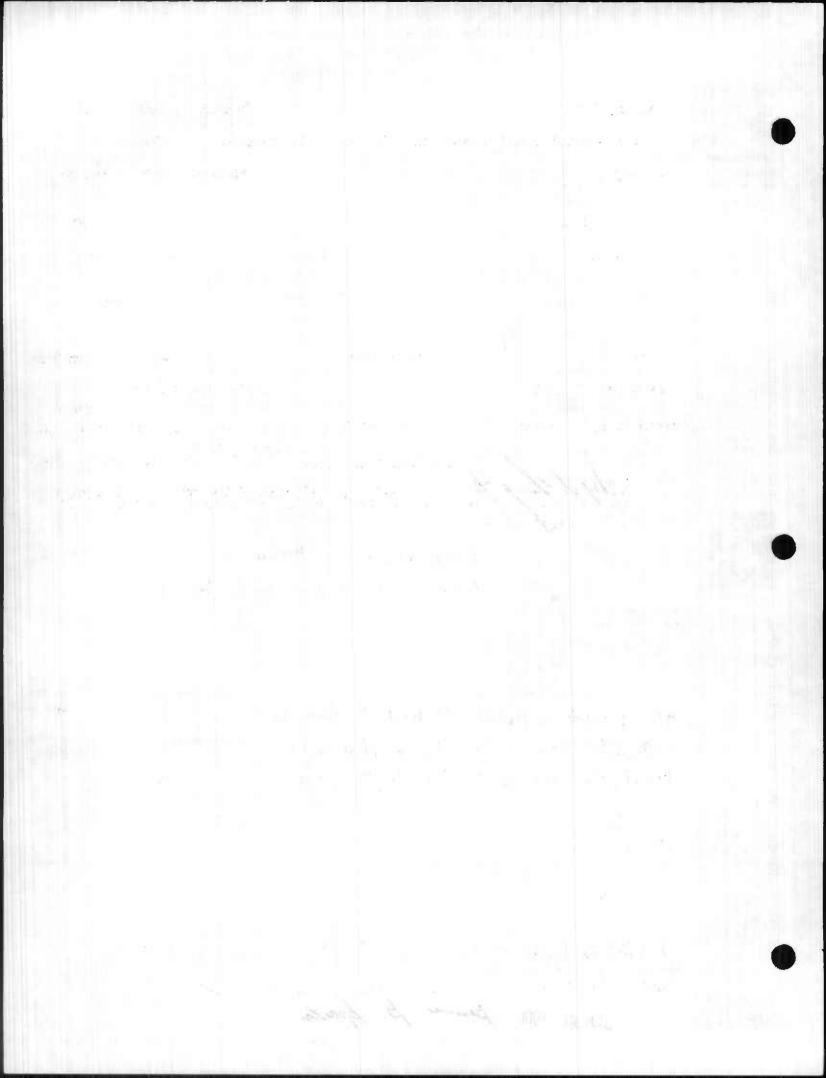
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Stoddard 100 Brown Street, Chestertown, Maryland 21620 31. Date filed (Month, Dey, Year)

State Registrar

2000 JAN 6





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** GEORGE LAYE 14:45 JANUARY 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MAKYLAND MCDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** 1⊠M 2□ F 01/18/1916 Director 83 204-07-5356 Usual Residence of Deceder 10a State 10b County 10c. City. Town or Location t 0d. Inside City Limits 1X Yes 2 □ No notified Directo Havre de Grace MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 pemit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Name 23s or any injury or other traumatic event, the Medical Examiner must be. USA Apt 401 21078 505 Congress Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1□ Yes 2 No Specify: Specify: White þ 3 NWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Plant Maintenance Engineer 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 80 Lenora Fadeley Randolph Laye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 622 Upper Valley Rd., Washington, Mass. 01223 George W. Laye, Jr.- Son Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Harford Memorial Grdns. 1/05/00 Aberdeen, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 23a. Pirit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and or heart feiture. List only one cause on each line. iviD 21078 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Respiratory -Examiner Examiner Sentia ettending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Mesenteric Ischemin E Hansine Box 68760 Physician/Medical Due lo (or as a consequence of signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Attending 1 Natural 5 Pending investigation effer death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours ef To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 296. Date signed (Month, Day, Year) 29b. Signature and title of certifier CREENE STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (041 ANESTHSIOLOGY DEPT. UNIVERSITY OF AMAECHI

DHMH 16 Rev 6/95

State

Registrar

ERONDY

31. Date filed (Month, Day, Year)

IAN 0 5 2000

62. Registrar's Signature

HOUL TO HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Sylvia Timberlake Lieske January 2000 9:30 am 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Residence: 4316 Highview Avenue Baltimore Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Months | Deys | Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Deys 1□M 2√2 F Yrs. 216-12-6467 April 11,1923 Maryland 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Maryland Baltimore 10e. Sfreef and Number 10f. Zlp Code 10g. Citizen of What Country? 4316 Highview Avenue 21229 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Sales Clerk Department Store 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumame) George Franklin Bines, Sr. Carrie Eoma Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joan E. Timberlake (daughter) 4316 Highview Avenue, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State Principio Cemetery 1/10/00 Perryville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Lee A. Patterson & Son Funeral Home 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown brillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21 No 1 ☐ Yes 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Yes 2 No

The lew requires that the deeth certificate be executed the burial-transit P.O. Box 68760, signed by the e Division of Vital Records, page 2 should certificate or Attending Physician: After this in by the funeral within 24 hours after death. To the Funeral Dirsctor: A

Physician /Medical

Examiner

Examiner

Physician/Medical

þ

Completed

Be

10

Medical

completely

945

Physician

/Medical

Examiner

Funeral

Director

rai", or items 23s or 28s-f shorex exemples at Examiner must be notified at

Director

Completed by Funeral

Be

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Heelin and Mental Hygiene. Important: if Item 27 is marked other than "near ony injury or other traumate."

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, streef, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

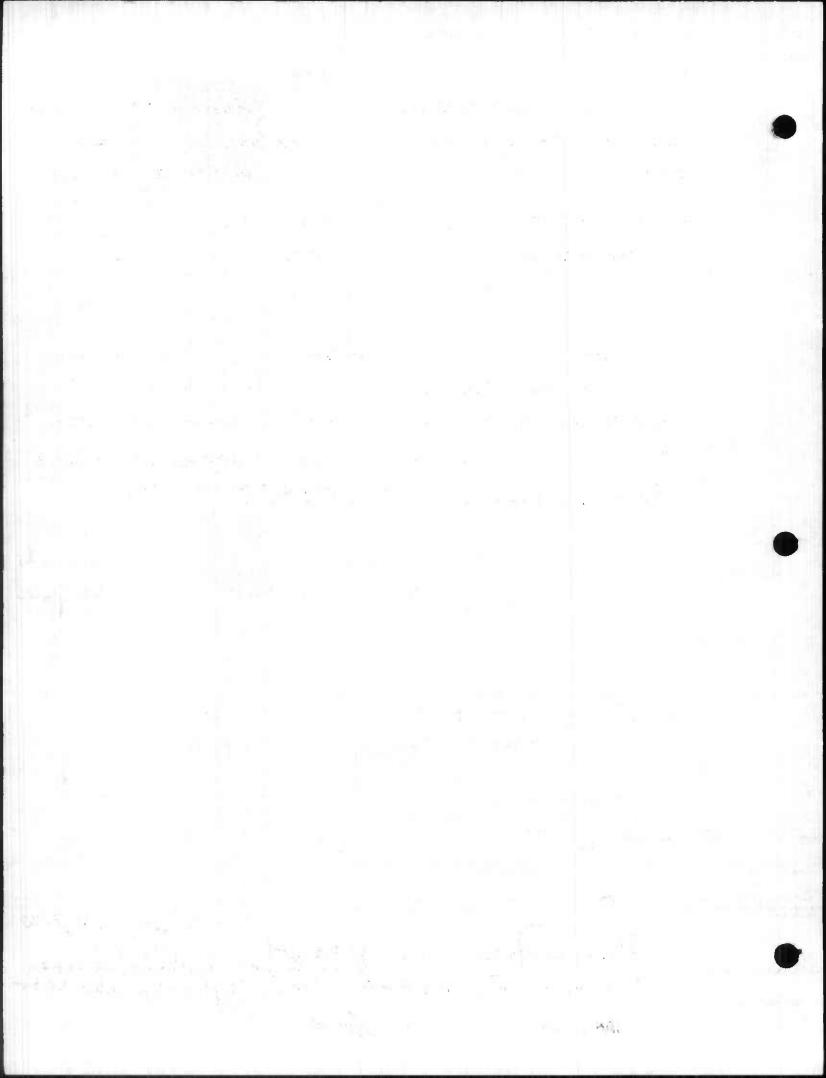
29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

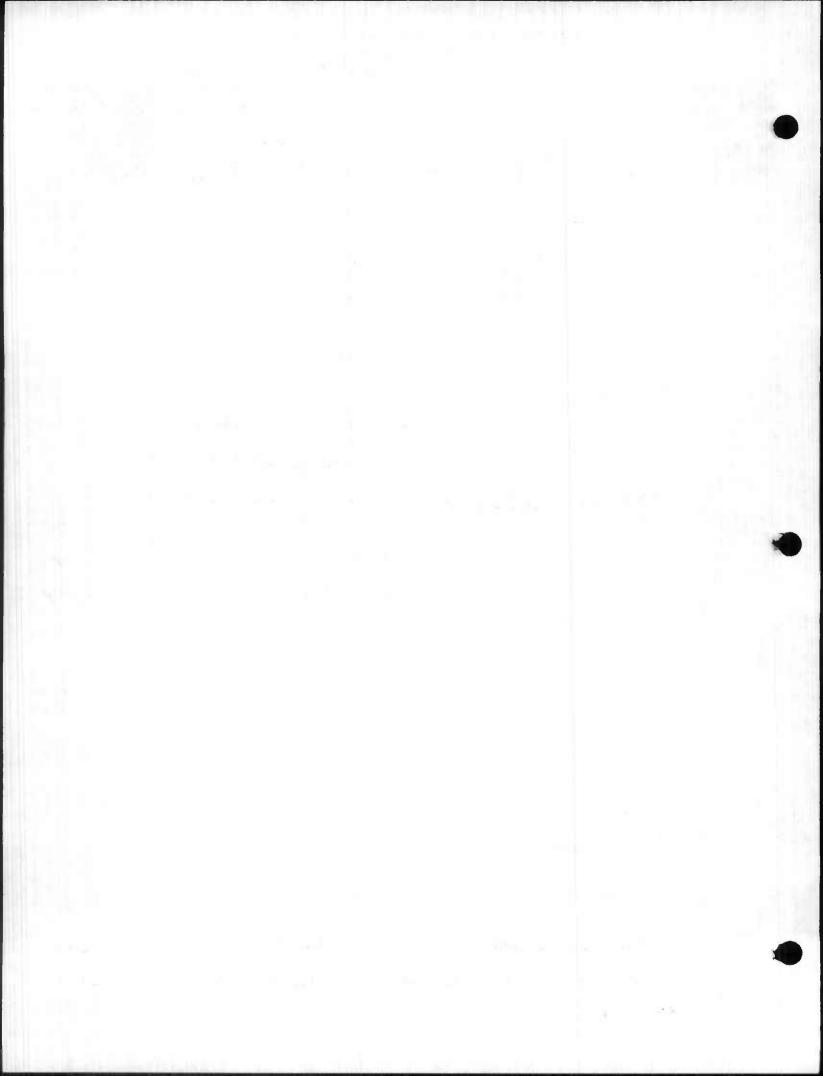
31. Date filed (Month, Day, Year)

32. Registrar's Signeture



			Decedent's Nam	e (First, Midd	le. Last)	-		Cel	tificate o	Deati	1	2. Dete of D	Reg. No.		3. Time of Deeth
п	Physic	an										Month	Dey	Year	2230
4	/Medi			rraine		el es com la el el				4h Oibi 1	Cours on L	JANVAR		2000	310 10
k	Exami	ner	4a. Fecility Neme (I			d number,						ocation of Dec		inty of Deeth Cecil	1
ш			Union H			Tale		4 * 44 . 4 . 1	If Lindor 1 Vos		lktor	_			
e.	Funeral Director		5. Social Security N 186–16–0	353	6. Sex 1 □ M 2√2		ge (In yrs. last 77	Yrs.	If Under 1 Yea Months Day		Min.	8. Dete of B (Month, 2 5/3/	Day, Year)	9. Birth	nplace (State or Foreig intry) PA
	and w.		Usual Residence of 10e. State	10b. County			10c. City, To	own or Lo	cation						t0d. Inside City Limita
	4 sho	6	MD	Cec	il		Port	Der	oosit						1 ☐ Yes 2 ☑ No
	the 128s	Director	10e. Street and Nur						10f. Zip Code				10g. Citizen	of What Cou	
	With with		391 Pr	incini	o Poad				219				US		artity :
	death	Funeral	11. Maritel Stetus	THETPT		Decedent	Ever In U,S.	13. V	Vas Decedent of		orlgin? (Sp	ecity Yes or N		Race - Amer	ican Indian.
21215-0020	72 hours effer death with the Maryland "naturel", or items 23a or 28a-f show solical Examiner must be notified at	by	1 ☐ Never Marri 3 ☐ Widowed		ried 1 ☐ Y	d Forces? es 2 2 Give or Dates:			Yes, specify Cu □ Yes 2√2 N	ban, Mexic	en, Puerto	Rican, etc.)		Bleck, White	
0-0	2 ho	Completed	(0	15. Deceder	it'a Education		16	Sa. Deced	lent's Usuai Occ	upation			16b. Kind o	1 Bualness/i	ndustry
218	C	pie	Elementary/Seco		st grade complet	e <i>d)</i> ge (1-4or:	5+)	(Give life. L	kind of work don OO NOT use retii	e during mo red)	st of work	ing			
21		6	12	, , , , , , , , ,				ho	omemaker					nome	
pu	be filed ital Hygid d other	Be (17. Father's Name	(First, Middle,	Last)					18. Moti	her's Name	e (First, Middl	le, Meiden Sun	name)	
Maryland	should be nd Mental in marked o	2	Harry	Morris	on					L	illia	an Pick	ell		
Mar	end end end end		19a. Informent's Na						g Address (Stre						ip Code)
	Haalth Haalth em 27		George P		Mason/hu	ısban			Principi	o Roa	d, Po		T		904
Baltimore,				Cremetion	3 □Removai fr	om State	0.000.0	of Dispo-	sition (Neme of netory or other p	lece)	1	Date /8/00		on-City or T ert, M	
Œ	permit. Pe Departmen Important sny injury		4 Donation 21. Signature of Fu				Brick		ends Me		Cem.	., 0, 00	OG I V		
Ba	permit. Peges Department of Important: If is sny injury or		Edwa	nlo	Z. Co	2 end	v. Ar.		Name and Add		•	ne, Oxf	ord, P.	A 193	363
			23a. Part 1. Enter the shock, or hear	he diseese, or rt failure. List	complications the	et caused on each ii	d the death. D	o not ente	er the mode of d	/ing, such a	s cerdiac	or respiratory	arrest,	1	Approximete Interval Between
ò	Physician													i	Onset and Death
Û	/Medical Examiner		Immediate Cause (disease or condition resulting in death)	n n	a	5,	opsia Due to (or as	Syn	drome					1	5 days
Ш		1	rooming in coamy				Due to (or as	a conseq						i	
	nsit n	nin			b	57	Tapk K		is Bac	terem	is_				5 days
_6	ficate be axecuted physician and is the burial-transit	Examiner	Sequentially list conditions, If eny, leading to Immediate cause, Enter Underlying												
68760,	siciar Siciar														
89	75 CD 00	ledical	resulting in death) L	ast			Due to (or as	a consequ	Jence ot):						
Box	death certing e attanding ed for use a	Physician/M			d										
	0 0 0	300	Pert II. Other signifi	leant conditte	ons contributing t	o death b	ut not resulting	in the un	iderlying cause o	iven in Par	H.	23b. Die	d tobacco uae	contribute 1	to the cause of death
P.0	at the by th	hy										1	Y88 2 1 N	o 3 Pro	bably 4 Unknow
Ś	ss that gned b	by I													
Vital Record	r requires been sign should be												s an autopsy formed?	24b. W	Vere autopay findings valiable prior to
ecc	aw 2 s	Completed												of	ompletion of cause death?
<u> </u>	0 - 0	10°										1□	Yes 2 PN	5 1	☐ Yes 2☐ No
ita	ysician: The s certificate director, per	Be	25. Was cese referr	red to medice						26. Plac	ce of Deatl	h (Check only	one)		
of V	5 00	To	1 ☐ Yes 2 ☑	No	Hospitai:	Inpatie	ent 2 ER/0	Dutpatien	3□ DOA C	ther: 4 N	lursing Ho	me 5 Res	sidence 6 🗆	Other (Speci	ify)
	ng Ph ter th neral		27. Manner of Deeth	5 Pendir		ate of Inju	ry 28b	. Time of injury	28c. inj W				how injury oc		
0	Attending Ir deeth.	atic	2 Accident	Investi	gation			,		Yes 2] No				
Division	or Attending efter deeth. Director: After I in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	ined 286. Pl	ace of Inj	ury - At home, c. (Specify)	farm, stre	et, factory, office	9			(Street and Nu	ım <i>ber or R</i> ur	ral Route Number,
	ital o														
	To the Mospital or At within 24 hours efter of To the Funeral Direct completaly filled in by	edical	29a. Certifier (Check only one)	1 Certifyin 2 ☐ Medical	g Physician: To Examiner: On th and n	the best e basis of nenner sta	exemination a	ge, deeth and/or inv	occurred et the estigation, in my	time, date e opinion, de	nd plece, ath occurr	and due to the ed at the time	e ceuse(s) end , date and ple	menner as a ce, and due t	stated. to the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier 29c. License number								29d. Date sig	gned (Month,	Day, Year)		
	->-0	Monte Makons, MD								-447	183		_		5,2000
	Q		30. Name end addre		who completed o	auee of d	leath (Item 23e) (Type, F	Print)						
	8				(045 MC	7	111 1	Nest	High	STre	et	ELF	TON,	MO	21921
	Sta		31. Date filed (Month		32	2. Registr	er's Signature	1				/	,		21921
	Registr	ar	ון מאת ע	200 0	pener	7	D. K	por	K						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 2 6

				Ce	ertificate	of	Death			Reg. No.	0	1660
		1. Decedent's Name (First, Middle,	Last)						2. Dete of De	eeth		3. Time of Death
	Physician	Hubert	Α.	Mart	tz				JANUAF	Dey 9 200	Year	9:30AM
	/Medical Examiner	4a Facility Name (If not institution,	give street and number)			-	4b. City, To	wn, or L	ocation of Dee			J. JUAN
	Lxammer	Sacred Heart	Hospital				Cumb	erla	and			legany
-	Funanci		-	yrs. last birthda	ff Under 1				8. Dete of Bi	rth	9 Birthn	elece (State or Foreign
	Funeral Director	214-07-5239	1GM 2□ F	89 Yrs.	Months	Days	Hours	Min.	Jul 3	1, 1910	Coun	PA
		Usual Residence of Decedent							10			
	Nemo Nemo	10a. State 10b. County	10	c. City, Town or I	ocation						1	0d. Inside City Limits
	Many to	MD Al.	legany	C	resapt	OW	n					1 No 2 No
	5 B 5	10e. Street and Number			10f. Zip C					10g. Citizen of W	het Cour	ntry?
	1 N	14917 Grant :	Street				21	502		USA		
	within 72 hours after deeth with the Maryland has "natural", or items 23s or 28s-1 show ha leafies leaming man be notified a impleted by Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13	. Was Decede	ent of H			ecify Yes or N	o- 14. Rece	- Amaric	an Indien,
	Par Fig.	1 Never Married 2 Marrie	Armed Forces?		If Yes, specif	ly Cuba	an, Mexican	, Puerto	Rican, etc.)	Bleck	, White,	etc.
22	lf. or by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yas 2	XNo	Specify:			Specify:	whi	te
Ö	natural.	15. Decedent's		16a. Dec	edent's Usual	Occup	ation			16b. Kind of Bus		
15	ed within 72 ho tyglene. or then "naturn it, the treates Completed	(Specify only highest	grade completed)	(Giv	e kind of work DO NOT use	done (durina mos	t of work	ring			
21215-0020		Elementary/Secondary (0-12)	College (1-4or 5+)	For	ner Em	npl	oyee			Textile		
	be filed other event, be Co	17. Father's Name (First, Middle, L.	ast)			ŤП	18. Mothe	er's Nam	a (First, Middle	, Maidan Sumame	1)	
lan	d be did	Harvey Martz					Cla	ra	(En	field)		
Maryland	요조를 = ⊢	19a. Informant's Name/Relationshi	io (Type, Print)	19b. Mai	ling Address ((Street	and Numbe	er or Rur	ral Route Numb	per, City or Town, S	Stata. Zio	(Coda)
×	and 2 and 2 27 le	Opal Martz	F (1) F-1.1.1.9						;Cresa			21502
0	- 2 5 5	20a. Method of Disposition		20b. Place of Dis	position (Name	e of		1	Dete	20c. Location - 0	City or To	own, Stete
Baltimore	Pages nent of I art: If No	1 Kurial 2 Cremation			emetory or oth							
Ħ	tant duy	4 Donation 5 Other (Spe	scify)	Sunset	Memor	ria	l Pa	rk	1/12/	Cumber	lan	d, MD
38	permit. Pages Department of Important: If it any Injury or page.	21. Signature of Funeral Service Li	censee	M- 1						me P.A.		
	70 F 4 0	Tucholas	2. Was	VII			-		ryland		2	
		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused the	death. Do not e	ntar the mode	of dyin	ng, such as	cardiec	or respiretory	errest,	1	Approximeta Intervel Batween
	Physician		0									Onset end Death
4	/Medical	Immediata Cause (Final disease or condition	. ACUTE	Rece	IRAT	TOR	Y F	ALL	URS			I week.
	Examiner	resulting in death)	Due	to (or as a cons	equence of):	-	-1				1	2
	licate be executed physician and is the burial-transit edical Examiner		Pinon	moni	6							1 mil
	physician and physician and sine burial-transit adicai Examir	Sequentially list conditions.		to (or es a cons	*						1	
ó	S SE X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									1	
68760,	indicate be executing physician and a sithe burlal-tran	that initiated events	C. Due	to (or es a conse	equence of):							
89	Med	resulting in death) Last									- 1	
Box	nding use		d								1	
	death e atter ed for u	Part II. Other significant condition	e contribution to death but o	of reculting in the	underhring car	use oiv	on in Part I		23h Did	tobacco use con	tribute to	o the cause of death?
0	d by the attend of the attend for us.		a contracting to could but in	or resorting in the	ondariying car	ose giv	OIT III T WILL					bably 42 Unknown
0	se that igned b be dete									105 2010	0	Date of the second
Records,	v requires that the death cer been signed by the attendin should be detached for use leted by Physician/N								24e. We	s an autopsy		era sutopsy findings
Ö	per									ormed?	CO	ellable prior to impletion of cause
ě	has pe 2											death?
	cata ha								10	Yes 22 No	1[Yes 2 No
Vital	Physician: The stational rai director, page To Be Co	25. Was case referred to medical examiner?	Hospital:			l Out		of Deel	th (Check only	one)		
o	T SE	1 ☐ Yes 2 Ø No	1 Inpatient	2 ER/Outpati			4 LI NI	ursing Ho		idence 6 Othe		(y)
_	Ther there on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Tima Injury		c. Injur Wor			28d. Dascribe	how injury occurre	ed .	
Division	or Attanding Ph after death. Director: After th I in by the funeral i in by the funeral	2 Accident investiga			М	10	Yes 2	No				
\equiv	Till by	27. Manner of Death 1								(Street end Numbe own, Stete)	er or Rure	al Route Number,
0	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi											
	ne Hoepital n 24 hours ne Funeral E pletaly filled edical Ce											
	To the Hospital within 24 hours and To the Funeral Completely filled	ane)	or trie time	, solo silo piaco, e	500 (1	2.0 02000(0)						
	within 2 To the comple	29b. Signature and title of certifier	29d. Date signed (Month, Dey,			Dey, Year)						
	4	D 23371								JANUARY	10	2000
	′	30 Name and address of person w	ho completed cause of death	(Item 23a) (Type	o, Print)							
	nus	(Vamas Zamas	N.N. 625	Kent L	tre C	un	nbo.	da	nd N	10 2	50	2
	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1	1,						
	Registrar	JAN T T 500	U Johnson	P	4000	2						

164 1 1800 Same of no man as

1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** January 10,2000 ANTHONY JOHN McMahon /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Devs | Hours | Min. | (Month, Day, Year) 5. Sociel Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months 18,1943 New York 56 Director 071-34-6211 December Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, tra Madical Examinar must be notified at La Plata MD Charles Director 10e Street and Number 10f. Zin Code 10a. Citizen of What Country? Apt.LL2 20646 1 Hickory Lane USA nthony Me Mahon 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If New Z7 is marked other than "n, any Injury or other traumatic event, the Mean and. Elementery/Secondery (0-12) College (1-4or 5+) Bar Tender/Police Officer Bar/Federal Govt 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Elizabeth Smith Joseph McMahon 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edward Smith/Brother 3120 Eutaw Forest Drive Waldorf, MD 20603 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Sacred Heart Cemetery1/13/00 La Plata, Md. 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licenses 22 AREHART-ECHOLS FUNERAL HOME, P.A. 50 P.O. BOX 567 LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of U Box 68760, 0

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician/Medical signed I by Completed page 2 s Be Medical Certification: To within 24 hours after death.

To the Funeral Director: Af

25. Wes case referred to medical

Records, P.O.

Division of Vital Attending Physician:

this

6 Hospital

within 2

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

completion of cause of death?

1 Yes 2 No

Approximate Interval Between Onset and Death

3. Time of Death

3:00AM

10d Inside City Limits

Yes 2 No

Hospitel:

1 Yea 2 LNo 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed?

1 Yes 2 1 No

Due to (or es a consequence of):

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Anpatient 1 Yes 2 1No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1X Neturai 5 Pending 1 Tyes 2 No Investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Piace of tnjury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifler (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year)

D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

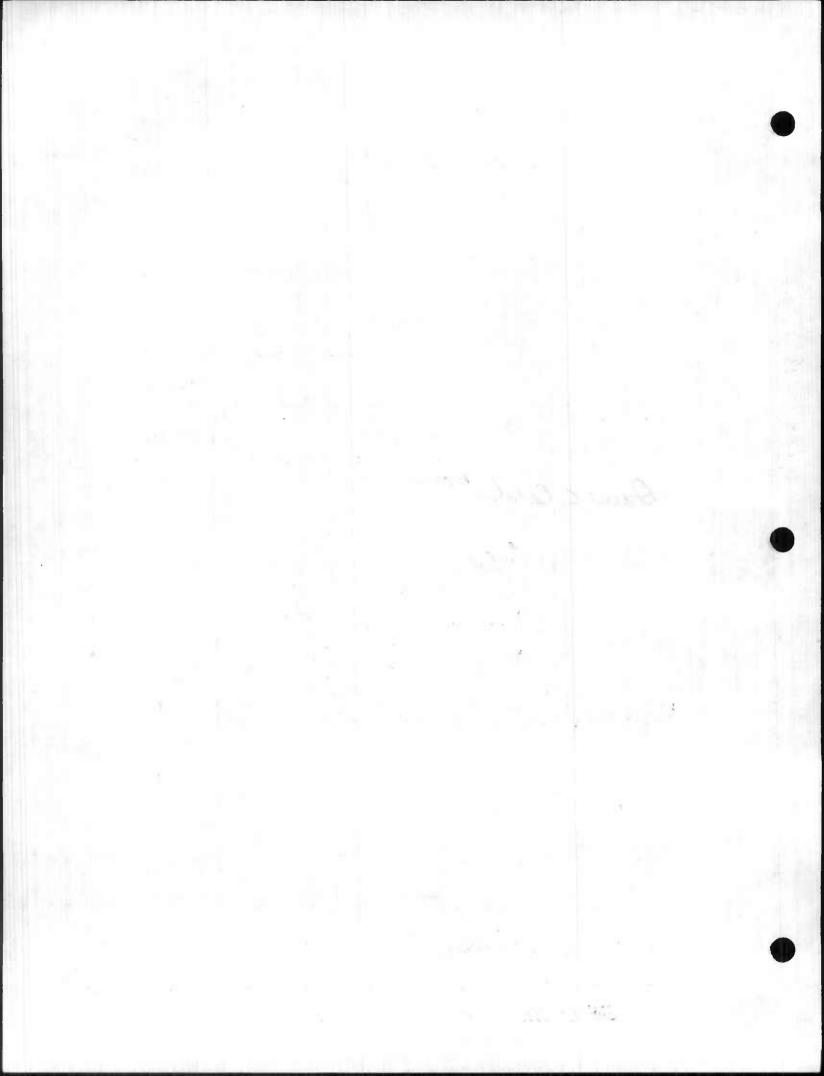
D

20646

Amir A. Mirza Alikhani, MD, FCCP 118 LaGrange Ave. P.O. Box 1890 La Plata, Maryland

State Registrar JAN 1 1 2000

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death SCOTT RENNE MCCLANAHAN JANUARY 8, 2000 3:17 PM 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street end number) 4c. County of Deeth SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 1 M 2□ F Months Deys Hours Yrs. 212-66-4910 APRIL 10, 1954 PENNSYLVANIA Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5100 MAIDENSTONE PLACE U.S.A. 20602 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR EXCAVATOR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALFRED 0. MCCLANAHAN, JR. DOLORES DAVIS Μ. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Relationship (Type, Print) NINA T. MCCLANAHAN/WIFE 5100 MAIDENSTONE PLACE, WALDORF, MARYLAND 20602 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlet 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) TRINITY MEMORIAL GARDENS 01-13-2000 WALDORF, MARYLAND 5 Other (Specify) of Funeral Service to 22. Name end Address of Fecility THE HUNTT FUNERAL HOME, INC BOX 156, WALDORF, MARYLAND INC. PUST ND 20604-0156 a BROHAWN M00053 G. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finel 1emorrhare disease or condition resulting in deeth) CD W/C Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings evallable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

Physician /Medicai Examiner

Injury or other

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23e or 28a-f show traumstic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer. Department of Health and Mental Hygiene. Important: If Item 27 ie merked other then "naturel", or Ite

Baltimore, Maryland 21215-0020

with the Maryland

death

requires that the death certificate be executed **burial-transit** and Division of Vital Records, P.O. Box 68760, physician the 57 บรล signed by the a d be deteched f hes page 2 certificate or Attending Physician: funeral director, this After To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A

Examiner

Physician/Medical by Completed Be P Certification:

29e. Certifier (Check only one) 29b. Signature and title of certifie

31. Date filed (Month, De

Neturel

2 Accident

3 Suicide

4 Homicide

28a. Dete of Injury (Month, Day Year) 5 Pending Investigetion

6 Could not be determined

Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

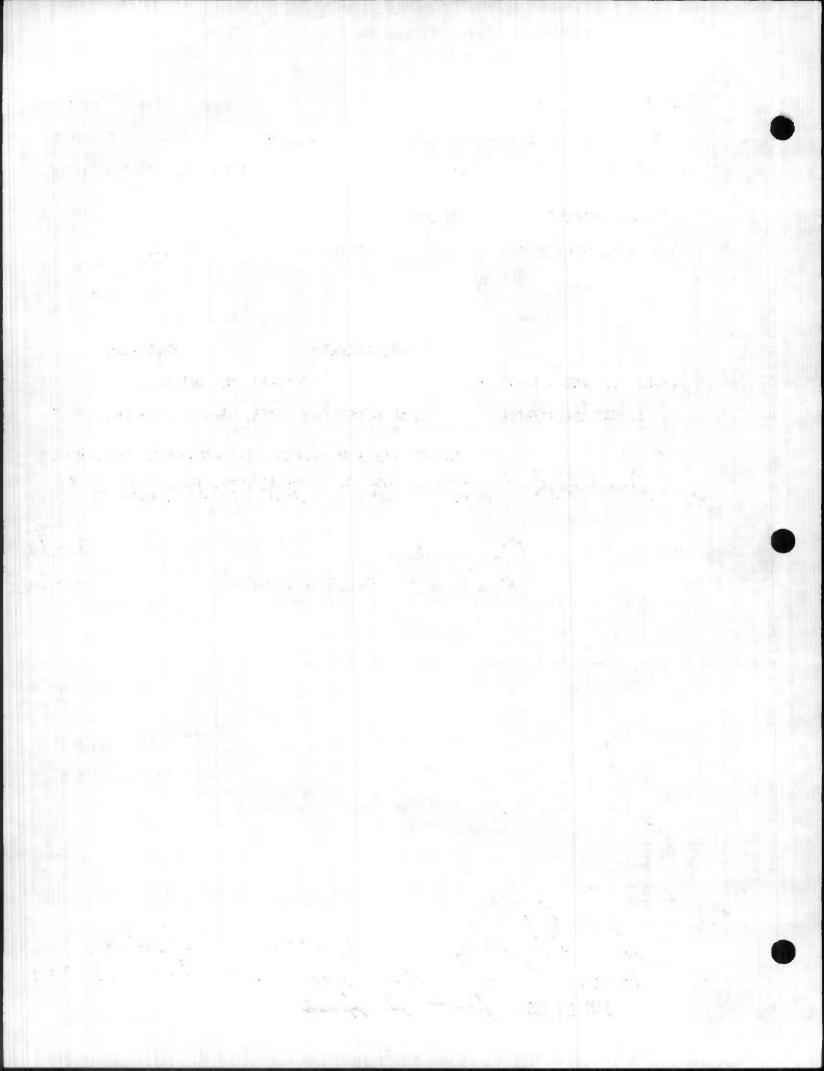
The Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner as stated. The Medical Examples: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the 667: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

81 and cause of deeth (Item 23e) (Type, Print) 30. Neme and address of

State Registrar

Medical

32. Registrer's Signeture JAN 1 1 2000

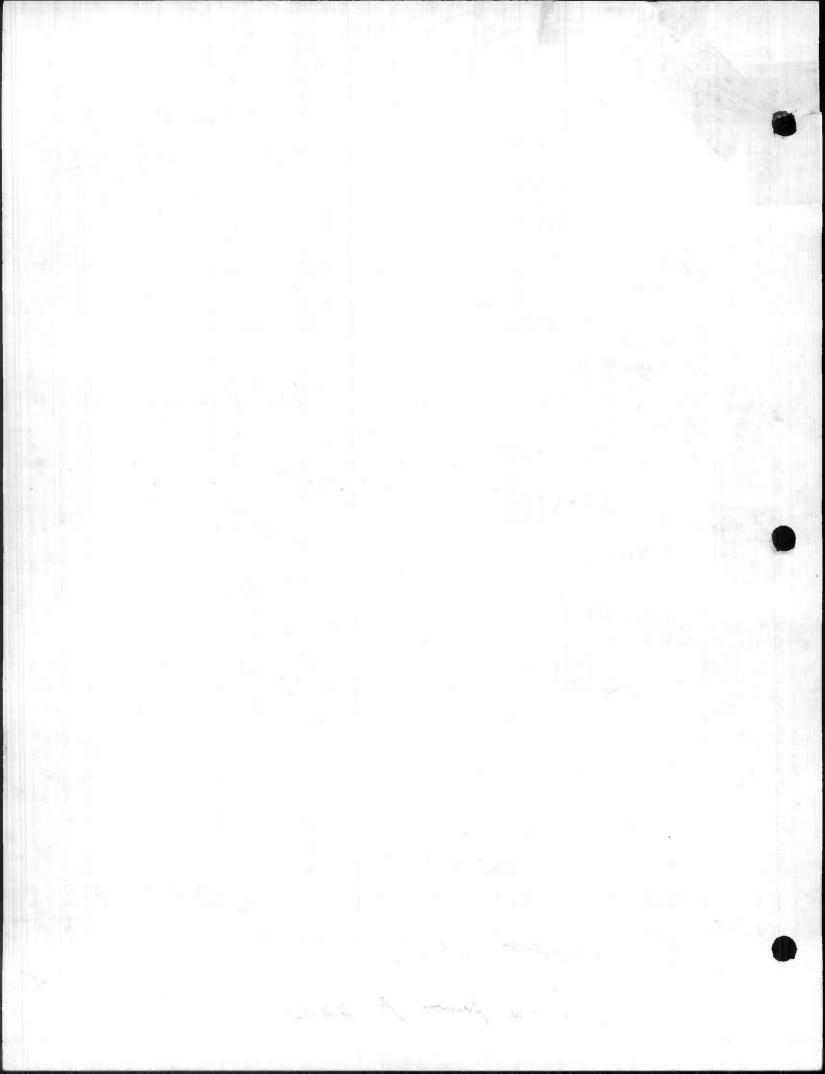


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

O, T.M. KentState of Maryland / Department of Health and Mental Hygiene

Residence of Citete Tand Pand Street and Number Of Lambarital Status Never Married Widowed 4 (Specify mentery/Second 12 ther's Name (F eS Meik nformant's Ner eCCa Me Aethod of Dispo	Decedent 10b. County Kent ber bs Meador de 2 Merried d Divorced 15. Decedent's Ecrity only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (2 ikle/Wiflosition Cremetion 3 5 5 Other (Specification) disease, or communication. List only Final	W Road 12. Was Decedent I Armed Forces? 1 Yes, Give Yeer or Detes: ducation ade completed) College (1-4or 5 3) (Type, Print) fe	Ever in U.S. No 20b. Place cerm Chris	t birthday) Yrs. fown or Locatic for ton 13. Was If Ye 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I Under 1 Year Ionths Days Ion Iof. Zip Code Is Decedent of I se, specify Cub Yes 2 Zi No I's Usual Occur of of work done NOT use retire Address (Street 78, WOI on (Neme of	4b. City, Town, or L Sal	B. Dete of Birth (Month, Day, March 28) March 28 ecity Yes or No-Rican, etc.) ing e (First, Middle, Note that Stave) all Route Number, 21678	4c. County of San	Deeth De
Residence of Citete Tand Pand Street and Number Of Lambarital Status Never Married Widowed 4 (Specify mentery/Second 12 ther's Name (F eS Meik nformant's Ner eCCa Me Aethod of Dispo	Decedent 10b. County Kent ber bs Meador de 2 Merried d Divorced 15. Decedent's Ecrity only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (2 ikle/Wiflosition Cremetion 3 5 5 Other (Specification) disease, or communication. List only Final	W Road 12. Was Decedent E Armed Forces? 1 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3 3) (Type, Print) fe	Ever in U.S. No 20b. Place cerm Chris	Town or Locatic Town or Locatic Torton 13. Was If ye 10. Lecedent (Give kind No	Index 1 Year Ionths Days Ion Days Ion Days Ion Days Ion Code I Decedent of I se, specify Cub Yes 2 Z No I's Usual Occur I of work done NOT use retire Address (Street 78, WOI on (Neme of	If Under 24 Hrs. Hours Min. 21678 Hispanic Origin? (Span, Maxican, Puerto Specity: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit	B. Dete of Birth (Month, Day, March 28) March 28 ecity Yes or No-Rican, etc.) ing e (First, Middle, Note that Stave) all Route Number, 21678	Ac. County of Sec. Spear) Og. Citizen of Wh. USA 14. Race Black, Specify: 16b. Kind of Busin Insuran Maiden Sumame) Ly City or Town, St.	Deeth Deeth Deeth Description Birthplace (Stete or Foreign Country) Country) 10d. Inside City Limits 1 Yes 2 No at Country? American Indian, White, etc. White ness/Industry Ce Itale, Zip Code)
Residence of Citete Tand Pand Street and Numl Pand Street and Numl Pand Street and Numl Pand Street and Numl Street	Decedent 10b. County Kent ber bs Meador de 2 Merried d Divorced 15. Decedent's Ecrity only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (2 ikle/Wiflosition Cremetion 3 5 5 Other (Specification) disease, or communication. List only Final	W Road 12. Was Decedent E Armed Forces? 1 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3 3) (Type, Print) fe	Ever in U.S. No 20b. Place cerm Chris	Town or Locatic Town or Locatic Torton 13. Was If ye 10. Lecedent (Give kind No	ion 10f. Zip Code 1	21678 Hours Min. 21678 Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit	B. Dete of Birth (Month, Day, March 28) March 28 ecify Yes or No-Rican, etc.) ing e (First, Middle, Met Stave) all Route Number, 21678	Og. Citizen of Wh USA 14. Race Black, Specify: 16b. Kind of Busin Insuran flaiden Sumame) Ly City or Town, St	Birthplace (Stete or Foreign Country) Onestertown, MD 10d. Inside City Limits 1 Yes 2 No at Country? American Indian, White, etc. White ness/Industry Ce Idate, Zip Code)
Residence of District and Number of District	Decedent 10b. County Kent 10b. Meador Mead	W Road 12. Wes Decedent E Armed Forces? 1 Yes, Give Yeer or Detes: ducation ade completed) College (1-4or 5 3 3) (Type, Print) fe	e (In yrs. last 59 10c. City, T W Ever in U.S. No 11 1:+)	Town or Locatic Town or Locatic Torton 13. Was If ye 10. Lecedent (Give kind No	ion 10f. Zip Code 1	21678 Hours Min. 21678 Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit	B. Dete of Birth (Month, Day, March 28) March 28 ecify Yes or No-Rican, etc.) ing e (First, Middle, Met Stave) all Route Number, 21678	Og. Citizen of Wh USA 14. Race Black, Specify: 16b. Kind of Busin Insuran Maiden Sumame) Ly City or Town, St	Destriction, MD 10d. Inside City Limits 1 Yes 2 No nat Country? American Indian, White, etc. White ness/Industry Ce Internal Code)
Residence of Citete Fland Street and Numl 96 Lam arital Status Never Married (Specifi mentery/Second 12 ther's Name (F eS Meik nformant's Nen eCCa Me fethod of Dispo Burial 2 Donetion 5 gnature 2 part 1. Enter the shock, or heer diete Ceuse (F	Decedent 10b. County Kent bs Meador ad 2 Merried 15. Decedent's Ecty only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (eikle/Wiff osition Cremetion 3 = 5 Other (Specification) disease, or com Wailure. List only Final	W Road 12. Wes Decedent E Armed Forces? 1	Ever in U,S. No 1 20b. Place comm. Chris	Town or Locatic Torton 13. Was If Ye 10. If Ye kind life. Do No. If Ye kind life. Do No. If Ye I I I I I I I I I I I I I I I I I I	Decedent of I say specify Cub Yes 2 No No T use retire Not use retire Not the North Manager of North Not use of North Not use retire Not use	21678 Hispanic Origin? (Span, Maxican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Rui cton, MD 2	ecity Yes or No-Rican, etc.) ing e (First, Middle, Net Stave) all Route Number,	Og. Citizen of Wh USA 14. Race Black, Specify: 16b. Kind of Busin Insuran flaiden Surname) Ly City or Town, St	Onestertown, MD 10d. Inside City Limits 1 Yes 2 No nat Country? American Indian, White, etc. White ness/Industry Ce
rland litreet and Numb litreet And Num litreet And Numb litreet And Num litreet And Numb litreet And Numb litreet And Numb litreet	Kent bs Meador ed 2 Merried d Divorced 15. Decedent's Edy only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (pikle/Wiff osition Cremetion 3 5 5 Other (Speciff heral Service Licent disease, or com Wailure. List only	12. Wes Decedent E Armed Forces? 1 Yes 20 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3) (Type, Print) fe	Ever in U,S. No 1 20b. Place Certical Chris	13. Was If Ye 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.	s Decedent of I be, specify Cub yes 2 MNo I susual Occup of work done NOT use retire Address (Street 78, WOI on (Neme of pay or other pla	Hispanic Origin? (Spen, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit Cton, MD 2	ecity Yes or No-Rican, etc.) ing e (First, Middle, Met Stave) all Route Number,	USA 14. Race Black, Specify: 16b. Kind of Busin Insuran Maiden Sumame) Ly City or Town, St	at Country? American Indian, White, etc. White Iness/Industry Ce
of Lamber of Lam	bs Meador ad 2 Merried 4 Divorced 15. Decedent's Ecry only highest grandery (0-12) First, Middle, Last) Kle me/Reletionship (2 ikle/Wiff osition Cremetion 3 5 5 Other (Specifi meral Service Licent disease, or comparity only finel	12. Wes Decedent E Armed Forces? 1 Yes 20 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3) (Type, Print) fe	Ever in U,S. No 1 20b. Place cerm Chris	13. Was If Ye I Y	S Decedent of I bes, specify Cub es, specify Cub Yes 2 No 's Usual Occup of of work done NOT use retire Address (Street 78, WOI on (Neme of pay or other pla	Hispanic Origin? (Spen, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit Cton, MD 2	ecity Yes or No-Rican, etc.) ing e (First, Middle, Met Stave) all Route Number,	USA 14. Race Black, Specify: 16b. Kind of Busin Insuran Maiden Sumame) Ly City or Town, St	American Indian, White, etc. White ness/Industry Ce
O96 Lambarital Status Never Marrier Wildowed 4 (Specify mentery/Second 12 ther's Name (F es Meik Informant's Nen ecca Me Method of Dispo Metho	bs Meador ad 2 Merried 4 Divorced 15. Decedent's Ecty only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (eikle/Wij osition Cremetion 3 D 5 Dother (Specif) meral Service Licent disease, or com waiture. List only	12. Wes Decedent E Armed Forces? 1 Yes 20 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3) (Type, Print) fe	p 20b. Plac cerni Chris	13. Was If Ye 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	S Decedent of I bes, specify Cub es, specify Cub Yes 2 No 's Usual Occup of of work done NOT use retire Address (Street 78, WOI on (Neme of pay or other pla	Hispanic Origin? (Spen, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit Cton, MD 2	ecity Yes or No-Rican, etc.) ing e (First, Middle, Met Stave) all Route Number,	USA 14. Race Black, Specify: 16b. Kind of Busin Insuran Maiden Sumame) Ly City or Town, St	American Indian, White, etc. White ness/Industry CE
arifal Status Never Merried Widowed 4 (Specification of 12 ther's Name (Fees Meik Informant's Name CCa Mee Aethod of Dispo Burial 2 Donetion 5 Grantum Fance, or heart Action of Perried Company of the c	ad 2 Merried 4 Divorced 15. Decedent's Ecty only highest grandery (0-12) First, Middle, Last) Kle me/Reletionship (eikle/Wij osition Cremetion 3 D 5 Dother (Specification) disease, or community of the control	12. Wes Decedent E Armed Forces? 1 Yes 20 Yes Give Yeer or Detes: ducation ade completed) College (1-4or 5 3) (Type, Print) fe	p 20b. Plac cerni Chris	16a. Decedent' (Give kind life. DO I) 19b. Meiling Av. DO BOX. 19b O BOX. 10 O Box. 11 U . 12. Ne	B Decedent of I as, specify Cub se, specify Cub Yes 2 No or's Usual Occup of the NoT use retire NoT use retal NoT use retire NoT use retire NoT use retire NoT use retire N	Hispanic Origin? (Spen, Mexican, Puerto Specify: pation during most of worked) 18. Mother's Nam Margare t and Number or Ruit Cton, MD 2	e (First, Middle, Net Stave) al Route Number,	14. Race-Black, Specify: 16b. Kind of Busin Insuran flaiden Surname) Ly City or Town, St	White, etc. White ness/Industry Ce
Never Married Widowed 4 (Specify mentery/Second 12 ther's Name (F es Meik nforment's Nen ecca Me fethod of Dispo Burial 2 Donetion 5 gnature 2 Pert 1. Enter the shock, or heer diete Ceuse (F)	4 Divorced 15. Decedent's Ecty only highest grandery (0-12) First, Middle, Last) Kle me/Reletionship (2 ikle/Wij osition Cremetion 3 5 Other (Specification of the companion of the compa	Armed Forces? 1 Yes Armed Forces? 1 Yes, Give Yeer or Detes: ducation ade completed) College (1-4or 5 3 2) (Type, Print) fe Diamoval from State by)	p 20b. Plac cerni Chris	16a. Decedent' (Give kind life. DO I) 19b. Meiling Av. DO BOX. 19b O BOX. 10 O Box. 11 U . 12. Ne	Yes 2 No 's Usual Occup d of work done NOT use retire Address (Street 78, Woll on (Neme of pry or other pla	specify: pation during most of work d) 18. Mother's Nam Margare t and Number or Rui cton, MD 2	e (First, Middle, Net Stave) al Route Number,	Black, Specify: 16b. Kind of Busin Insuran flaiden Sumame) Ly City or Town, St	White, etc. White ness/Industry Ce
(Specify mentery/Second 12 ther's Name (Fes Meik nformant's Neme ecca Medethod of Disposor Di	fy only highest grandery (0-12) First, Middle, Last) kle me/Reletionship (eikle/Will osition Cremetion 3 Cremetion 3 Cremetion 3 disease, or combailure. List only	College (1-4or 5 3 2) (Type, Print) fe Removal from State by)	20b. Place cerm Chris	(Give kind life. DO I	d of work done NOT use retire Address (Street 78, WOI on (Neme of	18. Mother's Nam Margare t and Number or Ruit Cton, MD 2	e (First, Middle, Net Stave) all Route Number,	Insuran Aaiden Sumame) Ly City or Town, St	CE late, Zip Code)
es Meik nforment's Nen ecca Me fethod of Dispo Burial 2 Donetion 5 pnature of Dentity Pert 1. Enter the shock, or heer diete Ceuse (F	kle me/Reletionship (pikle/Wif osition Cremetion 3 5 5 Other (Specifineral Service Licental Service Li	Type, Print) fe DRemoval from State by)	20b. Plac Chris	PO Box e of Dispositio etery, cremeto t I.U. 22. Na	78, Woll on (Neme of ony or other pla	Margare tend Number or Run rton, MD 2	et Stavel al Route Number, 21678	Aaiden Sumame) Ly City or Town, St	late, Zip Code)
es Meik nforment's Nen ecca Me fethod of Dispo Burial 2 Donetion 5 pnature of Dentity Pert 1. Enter the shock, or heer diete Ceuse (F	kle me/Reletionship (pikle/Wif osition Cremetion 3 5 5 Other (Specifineral Service Licental Service Li	Type, Print) fe DRemoval from State by)	20b. Plac Chris	PO Box e of Dispositio etery, cremeto t I.U. 22. Na	78, Woll on (Neme of ony or other pla	Margare tend Number or Run rton, MD 2	et Stavel al Route Number, 21678	Ly City or Town, St	late, Zip Code)
nformant's Nen ecca Me fethod of Dispo formation 5 ponetion 5 ponetion 5 ponetion 6 pone	me/Reletionship (pikle/Will osition Cremetion 3 5 Other (Specified) meral Service Liceo disease, or com deilure. List only	fe Removal from State fy)	20b. Plac Chris	PO Box e of Dispositio etery, cremeto t I.U. 22. Na	78, Woll on (Neme of ony or other pla	tand Number or Rui	al Route Number, 21678	City or Town, St	
ecca Me fethod of Dispo Burial 2 Donetion 5 pasture 2 Part 1. Enter the shock, or heer diete Ceuse (F)	eikle/Wiflostion Cremetion 3	fe Removal from State fy)	20b. Plac Chris	PO Box e of Dispositio etery, cremeto t I.U. 22. Na	78, Woll on (Neme of ony or other pla	cton, MD 2	21678		
Method of Disposition of Disposition 5 Donetion 5 Donet	osition Cremetion 3 5 Other (Specifieral Service Licenteral S	Removal from Stete (fy)	20b. Plac cemi	e of Dispositio etery, cremeto t I.U.	on (Neme of ory or other pla			20s Leasting Ci	
Burial 2 Donetion 5 Do	Cremetion 3	h) Lellov	Chris	t I.U.		109)	Dete 2		
Part1. Enter the shock, or heert	disease, or combailure. List only	Lellow.	3	22. Na	Cemete				
Part1. Enter the shock, or heart	diseese, or com dailure. List only	Lellow	15	22. Na Fe 1			./5/2000	Worton,	Maryland
se or condition ing in deeth) entially list cone, leeding to imm. Enter Underla diteleses or in littleted events ing in death) La	iditions, mediete tying	b	Nec of Due to (or as	s a consequen	nce off:	z»cıtıtı)			Onset end Deeth 2 days 1 H days 21 days
Other algnific	cant conditions c	contributing to death bu	ut not resultin	ng in the under	rlying cause gi	iven in Pert I.	23b. Did to	bacco una contr	ributa to the cause of death
							1 U Ye	e 2□No 3	Probably 4 Linkson
							24a. Wes en		24b. Were autopsy findings available prior to completion of cause of death?
							1076	s 2□No	1 ☐ Yes 2 ☐ No
es case referre	ed to medical					26. Place of Deel	th (Check only on	e)	
aminer? ☐ Yes 2☐→N	10	Hospitel:	nt 2DER	/Outpatient 3	3□ DOA Ot	her: 4 Nursing He	ome 5 Reside	nce 6 Other	(Specify)
nner of Death Neturel Accident Suicide	6 Could not be	(Month, Day	y Year)	Injury !	M 1	Yes 2□No			
☐ Homicide	determined	building, efc	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 1.00.0., 7, 000				
Certifier 1 Check only 2 one)	1 Certifying Ph	miner: On the basis of	examinetion	dge, death occ and/or investi	curred at the ti	ime, date and place, opinion, deeth occur	end due to the ca red at the time, da	ause(s) and manrate and place, an	ner es stated. ed dua to the cause(s)
	the obcertifier				29c. Licens	se number	25	9d. Dete signed ((Month, Day, Year)
ignative until li	The second second		M	0	BU	33011	21	1/2/0	1
ignatu s anti li	In	127			WIT .	10010.	-/	1700	
a.	m	completed sauce of de	eath (Ham 22	Re) (Type Drie	11				
ma and addres	ss of person who					21201			
211	ner of Death Neturel Accident Suicide Homicide	ner of Death Neturel 5 Pending Investigetic Suicide Could not be determined	I	1 Jumpatient 2 ER	1 Implation 2 ER/Outpatient	ner of Death Neturel Accident Suicide Homicide Continued 28e. Dete of Injury 28b. Time of Injury 28c. Inj	Neturel Scient Suicide Homicide See Place of Injury - At home, farm, streef, fectory, office See And S	Neturel Scient Suicide Homicide 28e. Dete of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28d. Describe homicide 28d. Location (Station (Station)) 28d. Location (Station) 29d. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, death occurred at the	Neturel Scient Suicide Accident Suicide Homicide See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury - At home, ferm, streef, fectory, office See. Place of Injury at Work? 1

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () ()

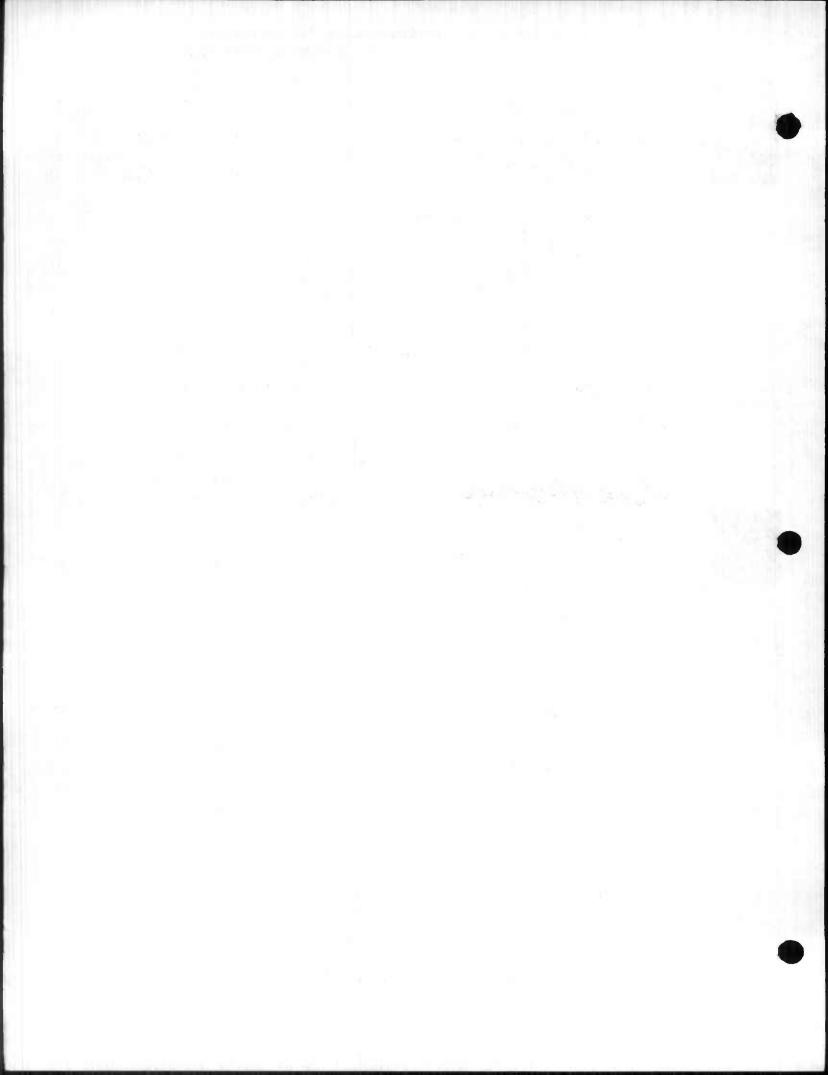
Certificate of Death

						Cei	rtificate o	f Death		Reg. No.		600	
Г			1. Decedent's Name (First, Middle,	Last)					2. Date of D	Peath		Time of Death	
	Physic /Medi		FLORA MAI	MURR	AY				JAN Month	02 2	000 2	305	
ì	Exami		4a. Fecility Neme (If not institution,	7	*			4b. City, Town, or		ith 4c. Count	y of Death		
			AVALON MANOR	R HEALTH	CARE			HAGERS	COMN	WASH	INGTON	1	
	Funeral Director		209-12-8660	3. Sex 7. A 1 □ M 2 🗓 F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Yes Months Day		(Month, E	lirth Day, Year) L4, 1906	9. Birthplace Country) Franklin	(State or Foreig	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation				104 1	naida Cit. Limite	
	daryte f sho	5	PA Frankli	n		encast	12.00					nside City Limits ☐ Yes 2 ☐ No	
	the the post	ect	10e. Street and Number		010		10f. Zip Code			10g. Citizen of			
	3a or	ā	109 N Allison	ST				7225		USA			
020	filed within 72 hours efter death with the Maryland Hyglene. Ther than "natural", or itema 23a or 28a-f show ent, the Medical Examine must be notified at	by Funeral Director	11. Marital Status 1 Nover Married 2 Marrie 3 Widowed 4 Divorcad	12. Wes Deceden Armed Forces	? [No	1		f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or N to Rican, etc.)		dlan,		
0-10	2 hor	te de	15. Decedent's	Education		16a. Deced	tent's Usual Occ	upetion		16b. Kind of Business/Industry			
Maryland 21215-0020	within 7 ane. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grede completed) College (1-4or	r 5+)		kind of work dor DO NOT use reti S Clerk	ne during most of wo	orking	Retail Store			
d 2	be filed withintel Hygiene. d other than event, the M	S	17. Father's Name (First, Middle, Li	est)		Darec	OLCLIN	18. Mother's Na	me (First Middl	e, Maiden Surnar			
an	S G G	o Be	John A. Murray	•					. Ather		,		
ary	d 2 should by	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Stre	et and Number or R			Stete. Zip Cod	e)	
	カチャラ		Donald L. Murray	Nephew	J		Pine RD			PA 1723		,	
re,	of Healt item 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p		Date	T	- City or Town,	State	
mc	Pege ent nt: If ry or		1 X Burlal 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		0		1 Cemet	· ·	Jan 5	Greenca	stle. I	ΡΑ	
Baltimore,	permit. Peges 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Li	ceptee	1		. Name and Add			rove Fur			
m	Depa impo		Ascement.	sowerse	9/	52	1 S Was	hington S		encastle			
			231 art1. Enter the disease, or c	omplications that cause	ed the death						Арр	roximete	
Я	Physician		shock, or heart feilure. List or	ny one cause on each	ime.						Ons	rval Between set and Death	
П	/Medical		Immediete Cause (Final disease or condition resulting in death)										
П	Examiner		resulting in death)	е		r as a conseq	uence of):					-340	
-	p ii	ine		- 6									
	certificate be executed using physician end use es the buriel-transit	Examiner	Sequentially list conditions,	U.	Due to (or	r es e conseq	uence of):						
68760,	cian cian		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C									
87	physi the l	Medical	that initieted events resulting in death) Last		Due to (or	as a conseq	uence of):						
×	ding i	Me		■ d									
Bo	ath	Physician/											
o.	that the death led by the atter detached for t	ıysi	Part II. Other algnificant condition							tobacco use co			
4	that led b		Anleino neles	ota cond	ina	anden	Bina	~	10	Yee 2 No	3 Probably	4 Unknow	
Records,	requires een sign hould be	ed by	Hopertuna	comes	Ansi	> 20	uen		24a. We	s an autopsy	24b. Were e	utopsy findings	
00	> 40 m	Completed	A						per	formed?	complet of deeth	e prior to tion of ceuse	
Re	The law ate has t pege 2 s	E C	Mucha De	hydration					10	Yes 2 No		2 No	
Vita	iclan: The certificate rector, peg	0	25. Wes case referred to medical					26 Place of Do			I L Yel	2 140	
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 I	ER/Outpatien	1 30 DOA	26. Place of De		sidenca 6 □Oth	or (Speciful		
of	y Phy eral		27. Manner of Death			28b. Time of				how injury occur			
Division	Attending or death. actor: After by the fune	27. Manner of Death 1 Chatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 Under the determined with the determined will be determined with the de											
Vis	Atte ecto by th	ific	3 ☐ Suicide 6 ☐ Could no determin	act 200. Place of If	njury - At ho	me, farm, str	eet, factory, offic	a	28f. Location	(Street and Numi	ber or Rural Rou	ite Number,	
ō	s efter	Cer	building, etc. (Specify) City or Town, State)										
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best amtner: On the basis of and manner s	of exemineti	viedge, death ion end/or inv	occurred at the restigetion, in my	time, date end place opinion, deeth occ	e, and due to the urred at the time	e cause(s) and m	anner as staled end due to the	cause(s)	
	To the within 2 To the complet	Me	29b. Signature end title of cartifier				29c. Lice	nse number		29d. Dete signe	d (Month, Day,	Year)	
			- @N	ZMO			D	18019		Jan 3	, 2007	5	
			30. Name and address of person wi	no completed cause of	death (Item	23a) (Type	Print)						
				334 Mill S		lagerst		D 21740					

State Registrar 31. Date filed (Month, Dey, Year)

JAN 0 5 2000

32. Registrar's Signature



permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or heres 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at ands.

To Be Completed by Funeral Director

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit

Physician/Medical Examine

Completed

B

2

Certification:

edical

SURESH DHAN
31. Dete filed (Month, Day, Year)

JAN 0 5 2000

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month January 4, 2000 Helen Malinowski 0155 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Cecil County Sun Bridge Nursing & Rehabilitation Center **Elkton** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Dele of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 X F 81 1918 May 30, 154-18-4434 Perth Amboy, NJ Usual Residence of Deceden 10a Stale 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No DE New Castle Bear 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 W. Bynum Place 19701 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Pace - American Indian Bleck, White, elc. 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Narleski Anna Zaorski 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Diane Juhrden - daughter 246 W. Bynum Place, Bear, DE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Memorial Park 1/6/2000 New Castle, DE 21. Signeture of Funeral Service Licenses 22, Neme end Address of Facility Spicer Mullikin Funeral Home 23a. Pert1. Enter the disease, or complications the crused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. 1000 N. DuPont Hwy. New Castle, DE 19720 Approximete tntervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting In death) CONGESTIVE HEART FAILURE 5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury thal initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION, DIABETES MECLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpalient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end mennar as staled.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signeture end title of certifier hullhaufau ofD 0 453 44 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

0

DHANJANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078
Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Richard Brinson Mann
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G780 G780 WBh

Reg. No.

Physician
/Medical
Examiner

Funeral Director

to be litted within 72 hours after death with the Maryland fettal typisme. Applane is recommended to the second to severe, the Medical Examiner must be notified at the event, the Medical Examiner must be notified at

nermit. Pages 1 and 2 should be titled within 72 hours after death Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Than "setures", or thems 3 any highty or other traumstic event, the Medical Examiner many any highty or other traumstic event, the Medical Examiner man

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

							v0-	3. Time of Death
ann								7:30 P.M
treet and number)				4b. City, Town, or				,
Street, Apa	rtmen	t 2		Hagerst	own.	Wash	ningt	on
7. Age (In y		Mor			Attach Day		9. Birtho	lace (Stete or Foreign try) Carolina
	03 T.	4						
	City, Town	or Location					10	0d. Inside City Limits
gton				lagerstow				1 Yes 2 No
		10	it. Zip Code		1	ug. Citizen of W		try?
		42 Was 5	Secondant of		Specify Vener No.	14 Page		an Indian
Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	, v,a.	If Yes,	, specify Cut	oan, Mexican, Puer	to Rican, etc.)	Black	k, White,	etc.
eation	16a. I	Decedent's	Usuel Occu	pation	orking	16b. Kind of Bu	siness/inc	lustry
	- '	lite. DO N	OT use retire	ed)	rking			
0			N	1				
						Meiden Sumam	9)	
				Covell	Mann			
oe, Print)								
				rth Avenu				
emoval from State	cametery	r, cremetor)	y or other ple					
Dimmein	uln						Max	212nd 2174
				ON			1	
Due to	(or as a co	onsequenc	a ot):				1	
Due to	(or as a co	onsequence	e ot):					
tributing to death but not i	resulting in	the underly	ying cause g	iven in Pert I.		1		
							av.	ere autopsy findings aileble prior to mpletion of cause death?
					1884	es 2 No	1.5	Ayes 2□ No
				26 Place of De			,	V.33 33
ospital:	□ FR/Out	patient 30	DOA O	ther:			er (Specif	v)
	28b. Ti	ime ot	28c. Inju	ury at ork?	7			
28e. Pleca of Injury - A building, etc. (Spe	t home, tan	m, street, ta	actory, office		28t. Location (S. City or Town		er or Rure	l Route Number,
ician: To the best of my ker: On the basis of exam end manner stated.								
er: On the basis of exam			ation, In my		urred at the time, d		end due to	the cause(s)
	Street, Apa: Street, Apa: 7. Age (In y.) 10c. gton Avenue, Apt 2. Was Decedent Ever in Armed Forces; 1 Yes, 2 kNo H Yes, Give Yes	Street, Apartmen 7. Age (In yrs. last birth 47 yrs	Street, Apartment 2 M 2 F 7. Age (In yrs. last birthdey) H Mod 47 Yrs. Mod 47 Yrs	Street, Apartment 2 M 2 F	Street, Apartment 2 Apartment 2	samn Street and number Street and number Street, Apartment 2 Hagerstown	### January 02, 26 ### January 0	Avenue, Apt. 2 2 Wes Decodent Ever in U.S. House 1 Seed North Avenue, Apt. 3 10 Decodents Issuel Competed: 10 Decodents I

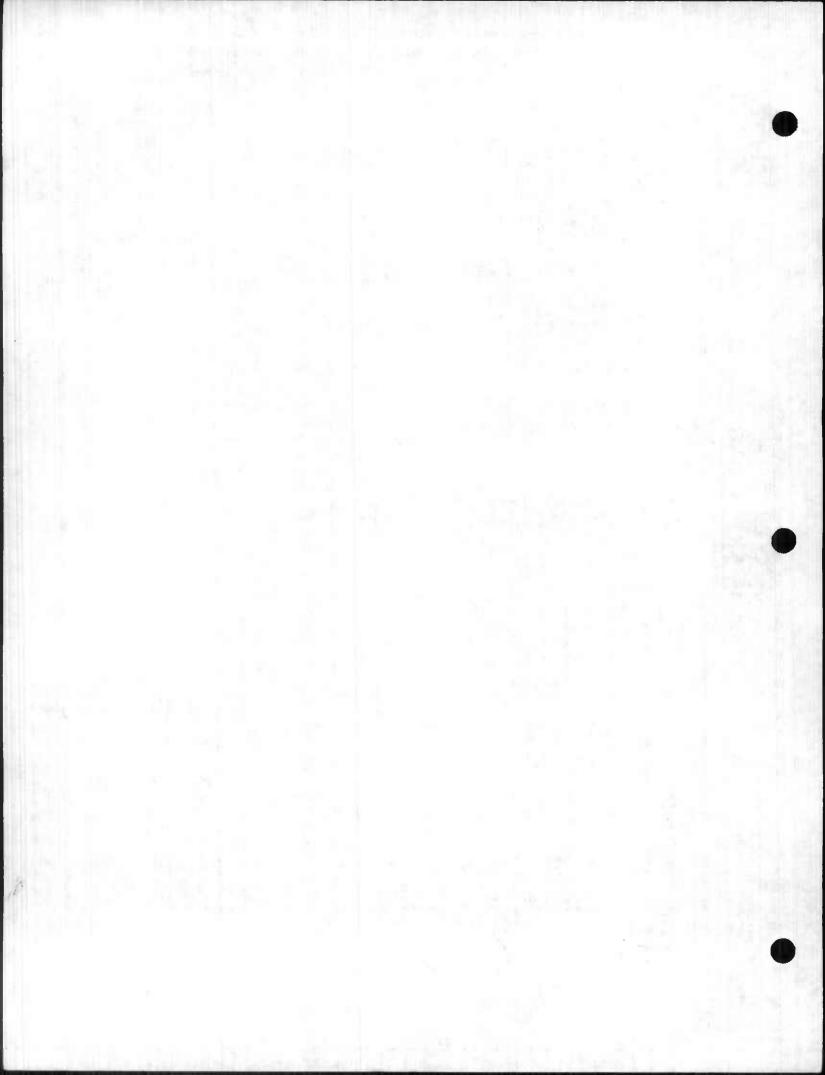
State Registrar 31. Date filed (Month, Dey, Yeer)

JAN 0 7 2000

32. Registrér's Signature

111 Penn Street, Baltimore, Maryland 21201

Aparla



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	2			Olate	or ivial ylai		tificate		Death		Reg. No.	0 (01533	
	Physician	1	1. Decedent's Name (First, Middle, L Joyce	ast) Ann		McDo	well			2. Date of Dec Month Januar	Day	Year	3. Time of Death	
	/Medica Examine	-	4a Facility Name (If not institution, gr	ive street and nu	ımber)			1	lb. City, Town, or Lo					
	Examinic	•	Sacred Heart	Hospit	al				Cumberla	and		A.	llegany	
	Funeral Director			Sex 1 M 2 F		. last birthday) 55 Yrs.	If Under 1 Months I	Year	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da Mar 2	2, Year) 194	9. Birth	place (State or Foreign ntry) WV	
	2	-	Usual Residence of Decedent		1									
	th with the Maryland 23a or 28a-f show		MD All	egany	10c. C	ity, Town or Lo Cu	mberl	an	d				10d. Inside City Limits 1 XYes 2 □ No	
	5 8 9	at Dir	10e. Street and Number 14101 Winches	ter Ro	ad		10f. Zip Co	ode	21502	3	10g. Citizen of V USA	Vhat Cou	ntry?	
020	or Rome		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	2 □ 400 ive	-	Was Decedent I Yes, specify		ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - Ameri k, Whita,		
21215-0020	ed within 72 hours after ygiene. her then "natural", or ite ft, tre Medical Exercine	pieted	15. Decedent's E (Specify only highest gr	Education rade completed)	00-120	16a. Decec (Give life. I	dent's Usual C kind of work of DO NOT use	Occup done d	ation during most of worki f)	ing	16b. Kind of Bu	usiness/Ir	ndustry	
21	r than		Elementary/Secondary (0-12)	College ((1-40r 5+)	Home	maker				Own Ho			
Maryland	H to y	0	17. Father's Name (First, Middle, Las Floyd Howerto						18. Mother's Neme		Maiden Surnam lace)	10)		
Mary	and 2 should saith end Men n 27 is marke er traumatic		19a. Informant's Name/Reletionship Vergie Marie	(Type, Print) Willia	ms	19b. Mailir 1840	ng Address (S	Street	and Number or Rura Road SE	Oldto	er, City or Town, WN MD	Stete, Zi	5 5 5	
Baltimore,	permit. Pages 1 end 3 Department of Heaith Important: If Item 27 i eny Injury or other tri ones.		20t. Method of Disposition 1											
Baltin	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Lice	**	MOOU	22	scarp	er	11 ^{Fa} Tune: and, Mai	cal Ho	me P.A		vn, MD	
5			23a. Part1. Enter the disease, or conshock, or heart failure. List and	plications that	caused the dea	th. Do not ent	er the mode o	of dyin	g, such as cardiac o	or respiretory er	rrest,	1	Approximate Interval Between	
	Physician											1	Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition		4 cyte	Res	pir-+	Bila	-4			his.		
			resulting in death)			or as a conseq	5	,			unthrown			
	and trans		Sequentially list conditions,	U	Due to (or as a conseq					1	1.		
50,	clan clan		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	5	-aw-	ch		Conci	nonea			unknown	
x 68760,	certificate be executed nding physician and use as the buriel-transit	3	that initiated events resulting in death) Last	d	Due to (or as a conseq	uence of):							
O. Box	y the attenched for) delega	Pert II. Other significant conditions	contributing to d	eath but not rec	sulting in the u	nderlying caus	se giv	en in Pert I.		V		to the cause of death	
0	£ 00 >									10	Yes 2/2/No	3 Pro	obably 4 Unknow	
Records,		24a. Was an autopsy performed? 1 Yes No									C	fere autopsy findings vailable prior to ompletion of cause if death?		
R	The Head	5								101	res No	1	□ Yas 2□ No	
	ysician: The secreticate director, pag		25. Was case referred to medical						26. Place of Death	Check only o	one)			
5	2 00 5		examiner?	Hospitel: 1/2	Inpatient 2	ER/Outpatien	t 3 DOA	Oth	er: 4 Nursing Ho	me 5 Resid	dence 6 □Oth	er (Spec	ity)	
o uois	auth. Arter th he funeral	27. Manger of Death Natural 5 Pending 28a. Date of Injury 28b. Time of thijury 28b. Time of thijury							ber					

To the Hospital or Attanding Phys within 24 hours effer death.

To the Funeral Director: Affer this completely filled in by the funeral di

Medical Certification:

State Registrar

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

6 ☐ Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

January

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

former to spirates

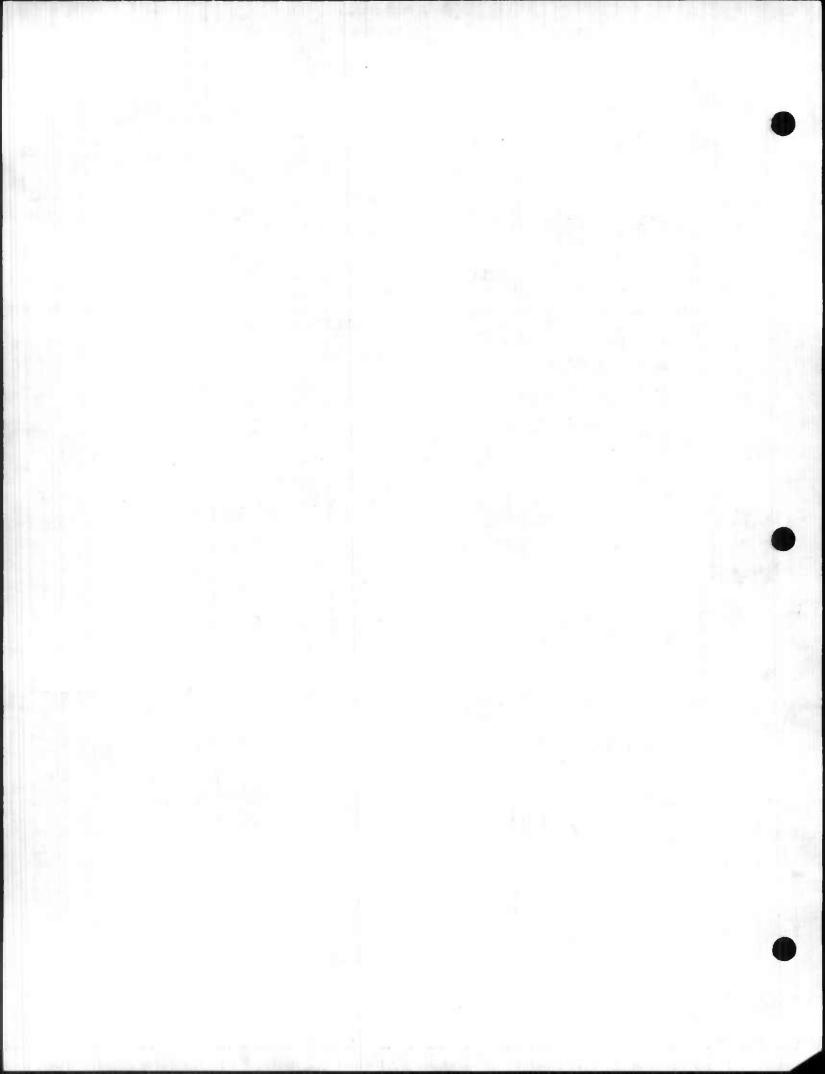
mer a gua

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:25P 3 2000 Hung Sun Mun January /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 250 F Yrs. Director 84 525-41-3095 May 26, 1915 Korea Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified 1 ☐ Yes 2 ☐ No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23s 917 Deer Ct. 21009 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 21215-0020 White 1 ☐ Yes 2 TNo Specify: Specify. à 3 Widowed 4 Divorced natural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 0 Homemaker Own Home marked other vith and Mental Hv-Baltimore, Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Yong Hwan Lee Dong Hui Park 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a : If Item 27 is Yong H. Kim / Daughter 912 Penobscot Harbor, Pasdena, MD 21122 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Pages 1 Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 8 permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1-7-00 Towson, Maryland Hilltop Service Corp. 21 Signature of Funeral Service Licenses 22. Name end Address of Fecility McComas Funeral Home, P.A. 23a. Part I. Enter the classe, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

Approximate Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last accident Mysvascu Physician/Medical 2 Due to (or as e consequence of) Pert tt. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 0 þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed LUSTON 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 80 26. Place of Death (Check only one) Hospitel: Inpatient 1 Yes 2N No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA Division of 1 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigetion of Puneral Director: A pletaly filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29e. Certifier (Check only one) To the P 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 18 2000 anuque 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walnut endeli 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) JAN 0 6 200 Registrar



Funeral Director

Director

Funeral

by

Completed

the Maryland 28a-f ahow 6 Нета 23а death

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" any injury or other traumatic event

Physician /Medical Examiner

213-24-6046

MARY MCCORMICK

Examiner physician and the burial-transit death certificate be axecuted Physician/Medical detached 0 Records, g Completed 584 page certificate Vital Be Certification: To To this Division or Attanding hours after death. Director: 3 To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by edical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Deta of Death Month McCormick JANUARY 1 2000 9:20 A.M. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital & Medical Center Cumberland Allegany 8. Data of Birth (Month, Day, Year) Apr 3, 1926 If Under 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 F 213-24-6046 73 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Kentucky Avenue 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No Specify Specify: white 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middle, Meiden Surnama) 17. Father's Nama (First, Middle, Last) John Aloysius Cavan (Madden) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code, 19e. Informant's Name/Relationship (Type, Print) John F. McCormick, 809 Louisiana Avenue; Cumberland 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery | 1/03/ Cumberland, MD 22Scarpelari Faruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or completations that caused the dishock, or heart feilura. List only one cause on each line. not entar tha mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Bety Onset and Death Immediata Cause (Finat disease or condition resulting in death) CORONARY ARTERY DISEASE 15 YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DIABETES MELLITUS 1□ Yes 1 ☐ Yes 2 ☐ No

25. Was casa referred to medical axaminer? Hospitel:

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yas 2 No

ner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29c. License number

28d. Describe how Injury occurred

26. Placa of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated
2 Medical Examiner: On the basis of examination and/or investigation in my applicant death.

29b. Signature and little of certific

axaminer?

27. Manufer of Death

Naturat

2 ☐ Accident

4 Homicide

(Check only one)

3 ☐ Suicide

D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, January

29d. Data signed (Month, Day, Year)

Suite Cumberland,

2000

State Registrar

ras

Sunil Gupta, JAN 0 7 2000

32. Registrar's Signatura

Johnson Heights Medical Building,

the fewer to species

1001 7 6 444

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 2340 Milton David Banyary 2000 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washingto Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year)
ADY 7, 1931 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 F Mid 217-28-0569 68 Director Usuat Rasidanca of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 1 ☐ Yas 2 ☐ No Director Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 26753 RR 2 Box 426 USA Nerns 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiena. Int: If Itam 27 Is marked other than "natural", or Ita 1 Nevar Married 2 Married 1□ Yas 2□No Baltimore, Maryland 21215-0020 Specify Specify: white by 3X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) Retired Employee WestVaco 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be (Hockman) David G. McIntvre Tessie 19b. Maiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
RR 2 Box 426; Ridgeley WV 26753 19a. Informant's Name/Ralationship (Type, Print) Department of Health ar Important: If Itam 27 is any Injury or other traugnos. RR 2 Box 426; Ridgeley Dorothy Keplinger 208. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Durlai 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Gap Veterans Cem1/07/ Flintstone, MD 21. Signature of Funeral Senfice Licenses 22 Scarperii Filineral Home P.A. Cumberland, Maryland 23a. Part 1. Effer the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting In daath) Cardio respiratory arrest Examiner Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaase or Injury Le myocardia
Dua to (or as a consequence of): that initiated events rasulting in death) Last renal disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably & Unknown 1 Yes 2 No þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 200 No 1 Yas 1 Yes 2 No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Attending 1'S Natural 5 Panding Invastigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant 6 ☐ Could not be detarmined 3 ☐ SuicIde 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12023 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Hagerstown Md 21742 MS 32 Registrar's Signatura State Registrar

David Milton

INTYre

and the most off the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Lumpkin Martha January 2000 Morris 6:35 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1 ☐ M 210 F Deys 218-16-8467 74 Feb. 24, 1925 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. Frederick Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 Jefferson Blvd. 21703 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2XXIO If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) own home homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 John Rhone Lumpkin Cornelia Knoop 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Morris (Husband) 5804 Jefferson Blvd., Frederick, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from Stele 4 Donation 5 Other (Specify) Smithsburg Crematory 1/8/00 Smithsburg, MD. 22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one trause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arcinomatos Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 1 Netural 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

physician and the burial-transit The law requires that the death certificate be associted Box 68760. USB BS P.0 Division of Vital Records. page 2 s certificate has To the Hospital or Atlanding Phyalcian: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, it edical Certification: To

Funeral

Director

or 28a-f ahon

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avent, the Medical Examinar must be notified at page.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and tilly of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) 000

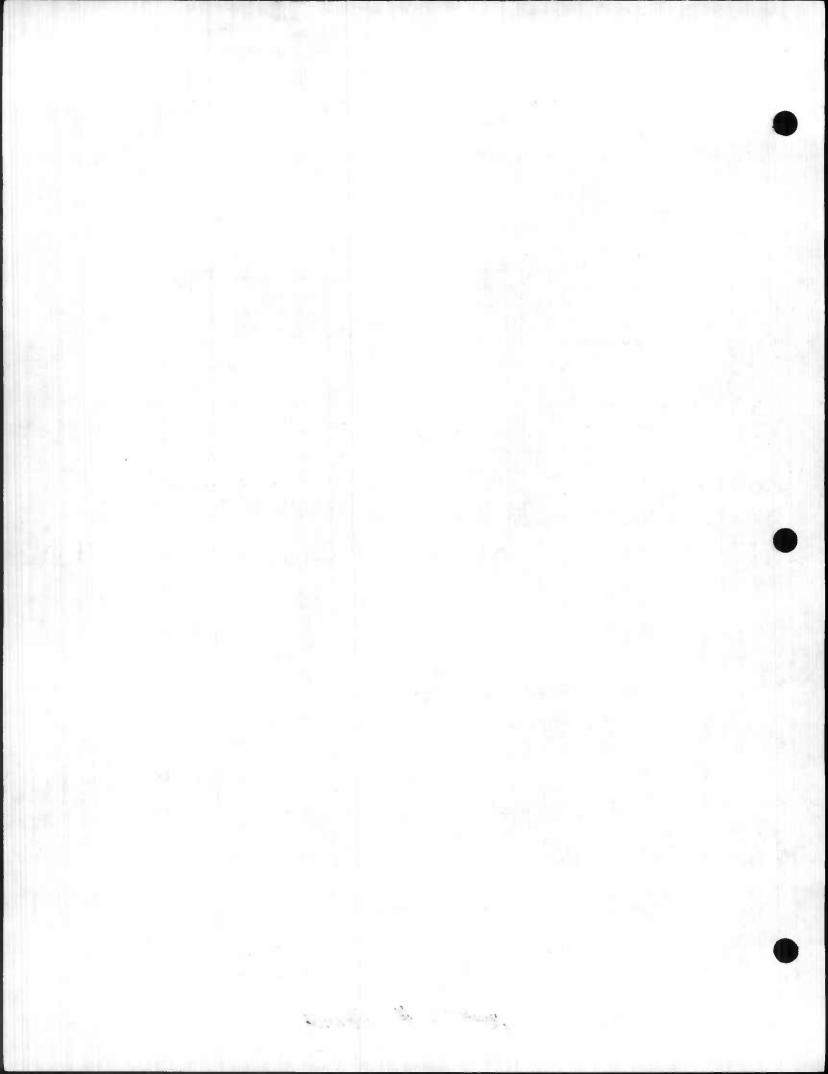
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eskander Mamy MD 31. Date filed (Month, Day, Year)

street Frederick MD 2170

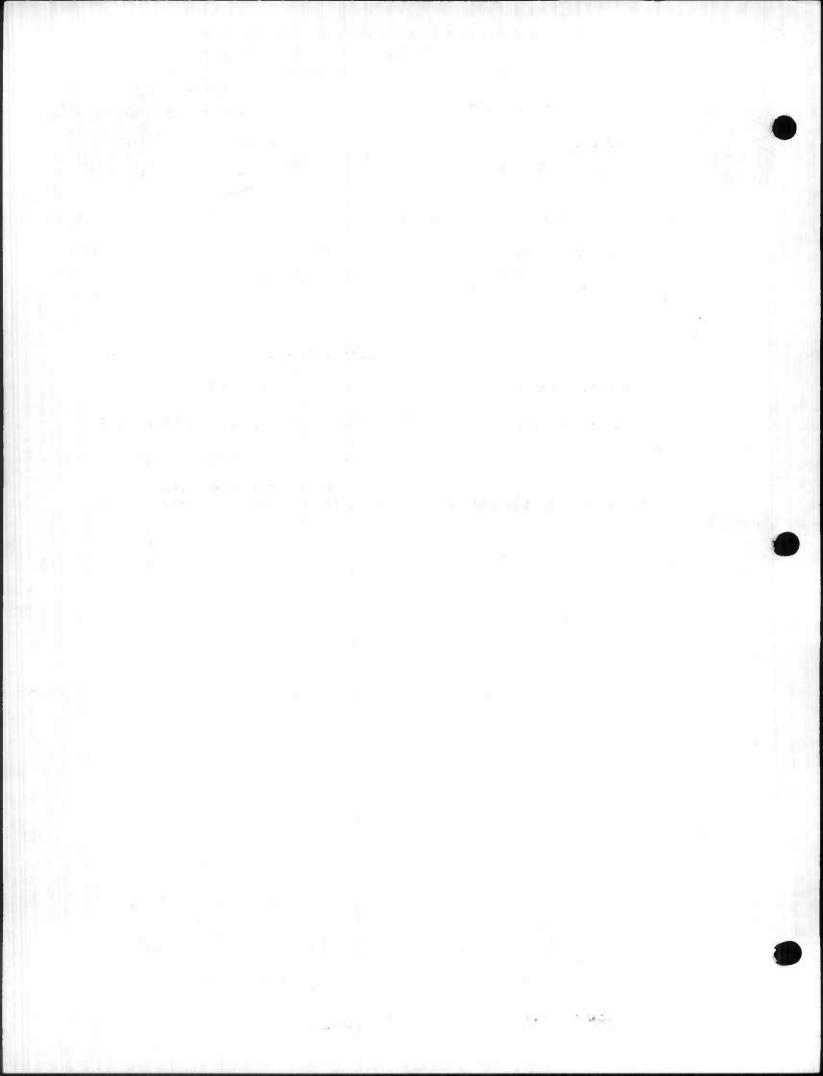
State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		1 Decedent's Name (First Mid # 5	actl		Cei	tificate	ot De	eatn	T	Reg. No.	-	140
Physic	ian	1. Decedent's Name (First, Middle, Last) Robert Nathaniel Nichols						2. Date of De Month	Day	Year	3. Time of Death	
/Medi		4a. Facility Nama (If not institution, g					4h C	Pilu Town or	Januar Location of Deati		dos O	1425
Examir	ner	Union Hospit		intoer)			40.0	Elkt		1 1 1 1 1 1 1	cil	
permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Department of Hiem 27 is merked other than "natural", or frems 23s or 28s-f show any injury or other traumatic avent, the Medical Example must be notified as once.			Sex	7. Age (In vrs.	lest birthday)	If Under 1 Y	ear If	Under 24 Hrs.	8 Date of Bir	th		aca (Stete or Foreig
		213-14-5213	1⊠M 2□F	76	Yrs.	Months D	ays H	lours Min.	(Month, De August	11, 19	23 Del	aware
		Usual Residence of Decedent							1 : 3		.1	
		10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limit
	cto	Maryland Ced	cil	E	lkton							1X Yas 2 No
or 2	Director	10e. Street and Number				10f. Zip Co	de 1921			10g. Citizen o	What Count	,
23a	2	107 Washington	-			2.	1921			UIII	Lea St	ates
Tem Ter	Funeral	11. Marital Status	Armed F		J,S. 13. V	Vas Dacedant I Yes, specify	of Hispa Cuban, N	nic Origin? (S lexican, Puert	pecify Yas or No o Ricen, atc.)		ace - Amarica iack, White, e	
9	by F	1 ☐ Nevar Marriad 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi			□ Yes 21🛛	No S	pecify:		Spec	ity: Wh	ite
la di			Year or D	Jates:	100 December	landa Harral O				400 100 1 4		
무성	Completed	15. Decedent's Education (Specify only highast grade completed)			(Give	lent's Usual O kind of work d DO NOT use re	ccupation one durin	ng most of wor	king	16b. Kind of	Business/Ind	ustry
then.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		nt/Sta:				Insu	rance	
Hygi ent,		17. Father's Name (First, Middle, Las			1.90	,			ne (First, Middle,			
ked c	To Be	Benjamin F. Ni	chols						ouise Me			
Tamer Transfer	-	19a. Informant's Name/Relationship			19b. Mailin	a Address (St	reet end	Number or Ru	ral Route Numbe	er. City or Tow	Code)	
of the contract of the contrac		Martha A. Nichol:	s/Wife		107 Washington Aver							
A E e e		20a. Method of Disposition			Place of Dispo	sition (Name o	of		Date		- City or Tov	
y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	cemetery, cren 1kton (-		į	1/7/00	Elkto	n, Mar	vland
ortar injui		21. Signature of Funeral Service Lice	•			. Name and A	-					2
Depa impo any i			1.	. ~					unerals, P.A.			
	_	23a. Part1. Enter the disease, or cor	8- Hu	رادحا					treet, E		MD 2	1921
		shock, or heart failure. List onl	y one cause on	each line.	un. Do not ente	ar the mode of	dying, st	ucii as cardiac	or raspiratory a	rest,		Approximate Interval Between Onset and Death
ysician Medicai		Immediate Cause (Final	1.	20/2	. 0	4.		,				90
aminer		diseasa or condition resulting in death)	a	nlracro			nor	hage				days
	ē			Due to (or as a conseq	uence of):					i	
physician end s the buriel-transit	Examiner	Sequentially list conditions	b	Due to (or as a conseq	uence of):					t	
an er uriel-t	Ä	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying										
he bu	dlcal	Cause (Disease or Injury that initiated events resulting in death) Last	C	Dua to (or as a consequence of):							-	
		Toodking in doubly East										
ed by the attending deteched for use a	Physician/M		d					1			1	
he at ed fo	sici	Part II. Other significant conditions	contributing to d	eath but not res	sulting In the un	derlying ceus	e given in	Part I.	23b. Did	lobacco uss d	ontribute to	the causs of death
by the	Phy								10	Yes 2 No	3 Prob	ably 4 Unknow
5.8	by										-T	
peen s	Completed								24a. Was perfo	an autopsy rmed?	ava	ra autopsy findings llable prior to
10 CV	pje	-									of d	pletion of cause eath?
ate ha	5								10	res 2 No	10	Yas 2□ No
s certificate director, pag	Be (25. Was cese referred to medical examiner?					26	. Ptace of Dea	th (Check only o	ne)		
80 TO	2	1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	3□ DOA	Other:	4 ☐ Nursing H	ome 5 Resk	dence 6 🗆 O	ther (Specify,)
or death. ector: After th by the funeral		27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date (Mon	of tnjury th, Dey Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe	now trijury occ	urred	
or: Al	atle	2 ☐ Accident Investigation	on					2 🗆 No				
tal or Attending is after death. al Director: After ed in by the fune	ertification:	3 ☐ Sulcida 6 ☐ Could not 4 ☐ Homicide determined	289. Place	of Injury - At hing, etc. (Specif	ome, farm, stre	et, factory, off	fice		28f. Location (S City or Tox	Street and Num vn, Stete)	nber or Rural	Route Number,
	O											
rei Dir	edicai	29a. Certifier 1 Certifying P	hysician: To the miner: On the b	best of my kno asis of examina	wledge, death	occurred at the	ne time, d	ate and place	, and due to the rred at the time.	cause(s) and r	nanner as sta	ited.
4 nours and Funeral Dir lely filled in	모	Grie)	and man	ner stated.								
the Funeral Dir	5	29b. Signature and titla of certifier	V		14 0		ense nui			29d. Data sign		ray, Year)
To the Funeral Dir.	Me	The state of the s	10-1-0	,	VI III	I N		7 1 -				
within 24 hours aft To the Funeral Discompletely filled in	Me) /	achol		nus		23.	322		1/4/	2000	
within 24 hours affer of To the Funeral Direct completely filled in by	Me	The state of the s	completed caus		n 23a) (Type, I				E Ton MI	/ /		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** HELEN ARLENE PIFER 1815 JAN 02 2000 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILSON HEALTHCARE CENTER GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 20 F 83 Yrs Director 188-09-5287 Usuai Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other trsumetic svent, the Modical Examiner must be notified at NE Yes 2 No Rockville 10f. Zip Code Directo MD. MONTGOMERY 10e. Street and Number 10g. Citizen of Whet Country? 713 Grandin Avenue 20850 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 any injury or other traumetic avent, the Medical Examiner must applice. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White by Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Purchasing Agent County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ira Shank Edna I. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 13320 Pepper Court Barry Pifer Germantown MD 20874 son 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Green Hill Cemetery Jan 6 Waynesboro PA use of Funeral Service License 22. Name and Address of Facility Grove Funeral Home, Inc. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, or heart failure. List only one cause on each line. Waynesboro PA 17268 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final myocardiae Inforction mhutes disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner Coronary Artery Dispase y-ears ettending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequenca of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown Hyperlipidemia, Renae Failure, Hypertension, þ 24b. Were autopsy findings evailable prior to 24a. Was an autopsy Completed Chronic Obstructive Pulmonary Disease completion of cause of death? 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No Hypothyroid 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 20 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: s effer death.
I Director: After of in by the funer After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Couid not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours o Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the I within 2 To the F 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Muscella Callabantya ND

30. Name and address of person who completed cause of death (item 23e) (Type, Print) January 3, 2000 041794

911 Russell

32. Registrar's Signature

Ave

Galtersburg MP 20879

State Registrar Priscille Callahan-Lyon, mo

31. Dete filed (Month, Day, Year) JAN 0 5 2000 August Agresses and the first of the contract of

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time f th 1. Decedent's Neme (First, Middle, Last) Day Month January 8,2000 Sarah Proctor 8:30 am 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Brandywine
Under 1 Year if Under 24 Hrs. 8. Da
Months Days Hours Min. Prince Georges 15400 Brandywine Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) Months 1 M 2 G Yrs. 88 May 20,11 216-38-6178 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15400 Brandywine Road U.S.A. 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) 7th Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Proctor Sumner Sallie Adams 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Beatrice P. Tignor/Daughter 170 Old Enterprise Rd, Upper Mar 20774 MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ST. Peters Cemetery 1/12/2000 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility M00191 Adams Funeral Home P.A. Aquasco, Maryland 20608 23a. Part . Enter the/disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory arrest, shock, or heer failure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Cause (Final Congestive failure Aculta Heart diseese or condition resulting in death) regurgitation Aortic Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or as e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown fibrilla Hon -Hypertension 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner lcian and buriel-trans Box 68760. attending physician certificate be the 80 950 ò signed by Division of Vital Records. 8 hes page 2

Examiner Physician/Medical by Completed Be 10 funeral Certification:

Physician

· /Medicai

Examiner

Funeral

Director

Show

Directo

þ

Completed

from 27 is marked other than "natural", or itema 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations.

Physician /Medical

Baltimore, Maryland 21215-0020

with the Marylend

deeth

certificate this After! il or Attending P. sefter death. To the Hospital within 24 hours e To the Funeral C Hospital completely

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

MD

29b. Signature and title of certifier 361 the

29c. License number D 28035 29d. Date signed (Month, Dey, Year) Janyary 11,2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

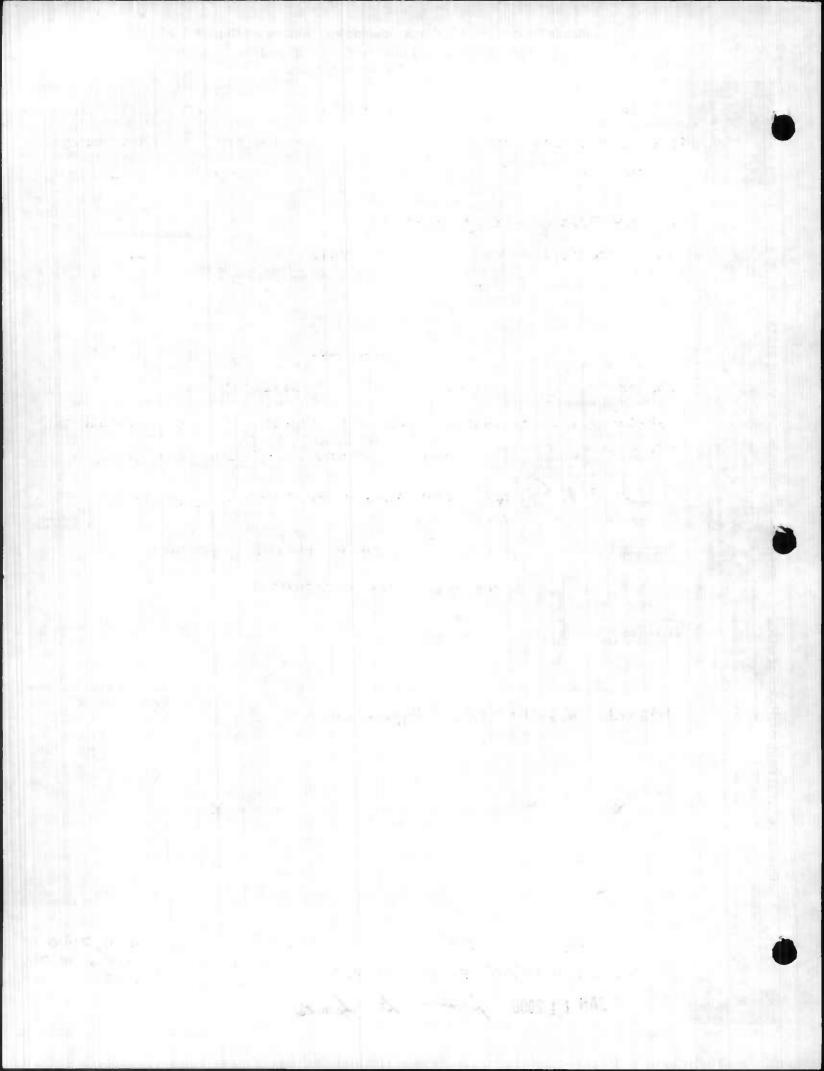
BASTRMOHMAD F. KOLTA. M.D. (1:25)

clinton. 100

State Registrar

Medical

32. Registar's Signature 1 1 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, Last)		2. Date of Death			3. Time of Death
hysician	Allen Leroy Preston		January	6 2	Year 2000	9:49 AM
/Medical Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or I		4c. County		7.47 1111
Adminici	Sacred Heart Hospital	Cumberla	ınd	All	egany	7
eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	r 1 Yeer If Under 24 Hrs.				lace (Stete or Forei
ctor	212-24-1216	Days 110013 Mill.	Feb. 8,		Mary	
1	10a. Stete 10b. County 10c. City, Town or Location				10	Od. Inside City Limit
cto	Md Allegany Barton					1 □ Yes 35N
al Director		1521		Difficen of W		
Funeral	11. Mental Stetus 12. Wes Decedent Ever in U.S. 13. Wes Dece Armed Forces? 13. Wes Dece	dent of Hispanic Origin? (Specify Cuben, Mexican, Puert	pecify Yes or No-		a - America k, White, e	
by	1 Never Married 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 3 Widowed 4 Divorced Yeer or Detes:	A STATE OF THE STA	o i boairi, etc.,	Specify		
be	15. Decedent's Education 16a. Decedent's Usu	el Occupation	16	b. Kind of Bu	sinass/Ind	lustry
Be Completed	(Specify onfy highest grade completed) (Give kind of wo life. DO NOT u	ork done during most of workse retired)	King			
Con	8 Maintenanc				-	ate Univ
Ве Соп	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden Sumame)			
10	John P. Preston	Glady	ys Moore			
To Be Comp		s (Street end Number or Ru OMAC HOLLOW	Barton,		State, Zip 1521	Code)
5	20e. Method of Disposition 20b. Place of Disposition (Ne.	me of	Dete 20	c. Location -	City or To	wn, Stete
5	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Lawn Mem		1/10/00	LaVa	lo M	D
DOCE.		nd Address of Fecility				<i>D</i>
g	1771/20 (Kn)	Funeral Home	111 Chi Western			21562
	23e. Part1. Enter the disease, or complications that caused the death. Do not enter the more			- '	עויי	Approximate
ian	shock, or heart feilure. List only one ceuse on each line.					Onset and Deeth
cai	Immediate Cause (Finel	12.1 2. ta	ant:			15-
ner	Immediate Cause (Finel disease or condition resulting in death) a. Acuta Myocan Due to (or as a consequence of) Covonary b. Due to (or as a consequence of) Covonary Cause. Enter Underlying Cause (Disease or Injury that initiated events	dal onja	reun		1	() minu
ě	CONCADA ACCU-	Te booi			1	11 6
Examiner	Sequentially list conditions Due to (or as a consequence of):	· wandosi	7		-	
	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): Covorred Covorred Covorred Due to (or as e consequence of):	oft scoom			3	O years
edicai		when or coro.	> 11			9-11-0
	resurring in death) Last					
Physician	d. Part II. Other significant conditions confributing to death but not resulting in the underlying of the conditions confidence of the conditions of the co	rause given in Part I	23h Did toh	acco use cor	atribute to	the cause of deat
hysic	11		12477.00	2 No		
2	Appertension, hyperchilestroles	nea				
	Hypertension, hyperchalestroles Diabetes wellets. Congestive &	2.0- 1-	24a. Wes en	eutopsy	ava	ere autopsy findings ailable prior to
. page 2 should	babetes welling injestive	rear			of c	mpletion of cause death?
Com	Failure.		1 ☐ Yes	2 PNo	10	Yes 2□ No
0 0	25. Was case referred to medical	26 Place of Dee	ith (Check only one)			
To B	examiner? 1 Yes 2 No Hospitet: 1 Inpatient 2 FR/Outpatient 3 De	Other:	ome 5 Residen		er (Snecify	()
	27. Menner of Death 28a. Dete of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how			,
atio	1 Naturat 5 Pending (Month, Dey Year) Injury 2 Accident investigation M	1 Yes 2 No				
led in by the funera Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fector building, etc. (Specify)	y, office	281. Location (Stre City or Town,	et end Numb	er or Rure	l Route Number,
e i	4 Homicide building, etc. (Specify)		City or Yown,	31010/		
completely filled in by the Medical Certifical	29e. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, deeth occurred 2 Medical Examiner: On the best of examination and/or investigation and menner steted.	at the time, dete and placa , in my opinion, deeth occu	, end due to the cau rred et the time, det	se(s) and ma e end place, a	nner as stand due to	ated. the cause(s)
completely filled Medical Ce	and monitor stores.	c. License number	290	f. Dete signed	Month. I	Dav. Year)
5	S(A HULL GI		TAN		
	o omoun Mw	114104		J / T IV	01.	2000
0						
6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
MAS		stburg, MD 2	1532			

DHMH 16 Ray 6/95

Will I was a married of the second

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

500 Memorial Avenue, Suite 201

4865

29d. Date signed (Month, Day, Year)

Cumberland, MD

1000

Physician

/Medical

Examiner

Funeral

Director

25a-f show

"natural", or hama 23s or 25s-f

Director

Funeral

à

Completed

Be 2

the Maryland

Baltimore, Maryland 21215-0020

filled willhin Then

permit. Pages 1 and 2 should be file.
Department of Health, and Mental Hy important: if Nem 27 is marked other any finjury or other traumatic.

Physician /Medical

Examiner

physician and s the buriel-transit

signed by the a

peeu

certificate

this

After

Director:

within 24 hours e To the Funeral D

death.

or A

\$

Physician/Medical

à

Completed

Be

10

Certification:

Medical

MA

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date fill AMONT. Ty. 2000

(Janes)

Robustiano Barrera, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/32. Registrar's Signatur

29a. Certifier

certificate be

Division Attending

50 0287

DHMH 16 Rev 6/95

ORIGINAL

Land of Sugar Sugar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death AND **Physician** KNWE GENE 4b. City, Town, or Location of Death 4c. County of Death 2000 /Medical 4a. Facility Nama (If not institution, giva street and number) **Examiner** HOSPITAL FUNDAR 24 Hrs. 8. Date of Birth (Mogth, Day, Year) FCB. 29, 1964 UNION CECIL If Under 1 Yaar Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 12 M 2□ F 209-54-8163 35 Yrs. Pa: Director Usual Rasidence of Dacedant the Maryland 10a State 10b. County show 10d. Insida City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at Pa Cheste 1 Yas 2 No Director HONEY Brook 10e. Sfreef and Number 10g. Citizan of What Country? with #3 U.S. A LANE death Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Rece - Amarican Indian, Black, Whita, afc. Wes Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Status 72 hours efter 1 Yas 2 No If Yas, Giva Yeer or Detas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2☑ No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "naturel", any Injury or other traumatic event, the Madical Execu-Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry NEWS PAPER Elementary/Secondary (0-12) Collega (1-4or 5+) PIESSMAN 9 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) PAUL Del Ray Roten

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ROWE 2 19a. Informant's Name/Ralationship (Type, Print) Hove / Brook PA GLOSIA A. ROWE-WIFE TROBULOS LANC 20b. Placa of Disposition (Nama of cometary, crematary or other place)

AND IEWS BI A GEMENNONITE 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 111/00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses FUNERAL Home 259 E. MAIN ST. Elkoung 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last and Dua to (or as a consequence of) Records, P.O. Box 68760. attending physician Physician/Medicai the Dua to (or as a consequence of) ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of cause of daath? peen 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital the Hospital or Attending Physician: 25. Was casa rafarrad to medical Be 26. Placa of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural 5 Panding Invastigation within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29b. Signature end fifia of certifiar 29c. Licansa number 29d. Deta signed (Month, Day, Year) Vales

State Registrar

JAN 1 0 2000

400-ISH

31. Data filled (Month, Day, Year)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

A PATEL

32. Registrar's Signatura

B. Sparks

OAST. EKTON, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year LEWIS RICHARDS JANUARY 2000 15:00pm 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Data of Birth (Month, Day, Year) May 31, 1930 Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Hours Months 1 X M 2 F Yrs. Pennsylvania 577-32-2107 69 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No St. Marv's Maryland Charlotte Hall 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 20622 29449 Charlotte Hall Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Evar in U.S. Armed Forcas? 1951-14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: 1954 Specify: White If Yas, Giva Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant'a Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Brick Layer Construction 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Lewis Richards Elizabeth M. Berninger 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Diane Beaghan/Sister 9608 Middieridge Court, Brandywine, Maryland 20613 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Dispo iition 20c. Location - City or Town, Stata 1X Bur 2 Crametion 3 Removal from Maryland Veterans' Cem. 01-12-2000 Cheltenham, Maryland 5 □Othar (Specify 22. Name and Address of Facility The Huntt Funeral Home, Inc MARK G. **BROHAWN** M00053 P.O. Box 156, Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death SEPSIS Immediata Causa (Final disease or condition resulting in death) PNEYMONIA ATION Dua to (or as a consequence of):

Physician /Medical Examiner

physician and s the buriel-trans

981

signed by t

this

After

To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Be

edical Certification: To

mew

the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. Slele

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death

72 hours after

illed within 7 I Hygiene.

permit. Pages 1 end 2 ahould be filed wit 60 Department of Health and Mental Hygiens A important: If item 27 is marked other the any filury or other traumatic event, If a page 2010s.

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

Be

Examiner Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

1 Yas 2 No

1 Yas 2 No

25. Was casa rafarred to medical	26. Place of Death (Check only ona)								
axaminar? 1 ☐ Yas 2 🖎 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	OA Other: 4 Nursing Homa 5	Rasidence 6 Other (Specify)						
27. Manner of Death Natural 5 Pending 2 Accidant Invastigation	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M	28c. Injury at Work? 1 Yes 2 No	scribe how injury occurred						
3 Suicida 6 Could not b 4 Homicida datarmined			ation (Street and Number or Rural Route Number, or Town, Stata)						

MELLITUS

29a. Cartifiar (Check only one) Certifying Phyalcian: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titia of cardie

BETES

29c. License number D 50653

20751

29d. Data aigned (Month, Day, Year) JAN. 07-2000

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

GYAN SURANA, DR . 31. Data filed (Month, Day, Year)

JAN 1 1 2000

DEALE, 32. Registrar'a Signatura

MD

MARYLAND,

DHMH 16 Rev 6/95

State

Sirie of the second

Omega-Alpha Cemetery

22. Name and Address of Facility

VISCOUS

Smith Funeral Home 85 S. Main Street

iner mant be a filed within 72 hours after 21215-0020 I Hygiene. Baltimore, Maryland Pages 1 and 2 should be nent of Health and Merits! nt of Health a If Item 27 is or other tre

Physician

/Medical

Examiner

10a. State

Directo

Funeral

Director

25a-f

the Maryland

Physician /Medical Examiner

sician and burial-transit physician s the burial

Physician/Medical þ page 2 should be Completed funeral director, Be After this Attending death. 6

216-14-1444

Roach

Box 68760, Vital Medical Certification: To ō Division within 24 hours after deat To the Funeral Director: filled in by completely To the

Funeral by 3 ☐ Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) ä Harvey Lee Somerville 19a. Informant's Neme/Relationship (Type, Print) Wayne J. Roach/Husband 20e. Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Driano 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) · XCUTE PEKITOPITIS EKFORATSO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 25. Was case referred to medical examiner? 1 Yes 2 TNo 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

29b. Signeture and title of certifier

Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 100 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 D Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Jan. 2000

Keyser, WV

26726

Approximate Interval Between Onset and Death

PAYS

Keyser, WV

8 Could not be determined 3 Suicide 4 ☐ Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

500 Memorial Avenue, Suite 201, Cumberland, MD 21502 Robustiano Barrera, M.D., 31. Dele filed (Month, Day, Year) JAN 1 0 2000

State Registrar

32. Registrar's Signature

The state of the s

America # 206, 200; Pleas Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jan. 8, 2000 **Physician** Gracia D. Richardson 5:00 p.m. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner 13501 Uhl Highway Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) June 18, 1942 Birthpiece (Stete or Foreign Country)
 NY 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2₽F 57 Yrs. Director 128-34-4135 Usual Residence of Decadent with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at ¥ Yes 2□No Directo Allegany Cumberland 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 13501 Uhl Highway 21502 USA death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Meritei Stetus permit. Pages 1 and 2 should be filed within 72 hours after. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, its lead all Esseries. 1 Never Merried 2 Married 1 ☐ Yes 2☐ No Specify: Specify: by White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Grace (Davis) Irving Yousett 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13501 Uhl Highway Cumberland MD 21502 Orville Richardson-husband 20b. Piece of Disposition (Neme of cometery, cremetory or other place)

Scarpelli Erematory

PA 20c. Location - City or Town, State 20e. Method of Disposition Chesaptown 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State 01/09 Cumberland MD 4 □ Donetion 5 □ Other (Specify) 21. Signetate of Funerel Service Licanom 22. Neme end Address of Fecility Scarpelli Funeral Home, P.A. Cumberland, MD 23a. Part1. Enter the disease, or complications that cause does shock, or heert failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Intervai Between Onset end Death Ph_sician Respiratory Failure acute
Due to (or es e consequence ot): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Obstructise Pulmeran Disease Physician/Medical Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? ed by the deteched signed by to 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 105 28 No certificate Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2No 9 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 DOA this funeral 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Aftert or Attending 5 Pending Investigation 1 □ Yes 2 □ No death. Il Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 HomicIde To the Hospital or A within 24 hours after To the Funeral Directornibles of the first completely filled in by 29a. Certitier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. edical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. 29b. Signature and title of petities 29c. License number 29d. Dete signed (Month, Day, Year) 10 ed cause of deeth (Item 23e) (Type, Print) Douglas Avenue, Coracoring and 21539 20 32. Registrer's Signeture Registrar

DHMH 16 Ray 6/95

Green to directed

noor 6 1 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Amended item#17.01/11/00.FCHD.KS Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dey **Physician** Deloris January 1, 2000 Yvonne 5:36 a.m. /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1□M 2⊠F Months Hours 62 214-34-0997 Jan. 16, 1937 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 1 Yes 2 □ No Director Maryland Frederick Walkersville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ò Ната 23а 5 Monocacy Court 21793 Funerai United States 14. Rece - American Indien, Black, White, etc. 12. Wes Decedant Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If New 27 is marked other than "natural". or Manay injury or other traumatic ayard. Armed Forces? 1 Yas 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 X Married 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Air Conditioner 12 Custodian Manufacturer 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Marchall Samuel Hann Catherine Elizabeth Krise 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall B. Rice / Husband 5 Monocacy Court Walkersville, Maryland 21793 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata Dete 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Removal from State 5 Creagerstown, Jan. 4 Donation 5 Other (Specify) 1999 John's Lutheran Cem. Maryland 21. Sign elure of Furteral Service Licensee 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. 40 Fulton Avenue Walkersville, Maryland 21793 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or head feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final sew mits disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Completed by Physician/Medical Dua to (or es e consequence of) U\$8 for Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 ☐ Unknown 1 € Yea 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Grellitin 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ETER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding NA 1 ☐ Yes 2 ☐ No

the deeth certificate be executed Box 68760 P.0. Records, Division of Vital or Attending Physician: death. 124 hours after death. le Funeral Director: A bletely filled in by the f Hospital To the Hosp within 24 hos To the Fune completely fi

Meryland

death

State Registrar

edical

31. Dete filed (Month, Dey, Year)

29b. Signature and titla of certifier

2 Accident

4 ☐ Homicide

(Check only one)

3 Suicide

29a. Certifier

Invastigation

6 Could not be

MAJEBD MB 32. Registra s Signeture 2000

rasz.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOU HOUSE ALE FREDERICK MD 21701

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and menner steted.

29c. License number

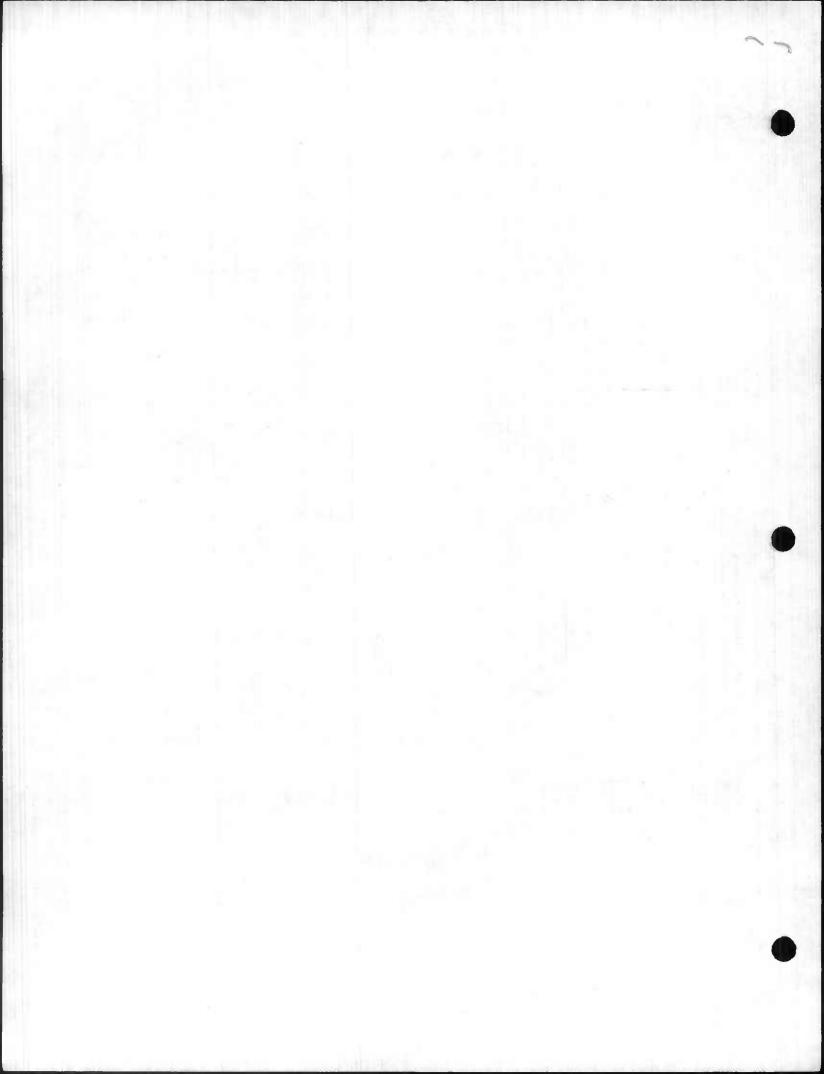
D18063

281. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

28e. Pleca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

MM



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		otate of maryland		te of Dea			leg. No.	0 01518	
Discontinuo	1. Decedent's Neme (First, Middle, Last)					2. Dete of Dea Month		3. Time of Death	
Physician /Medical	Samuel Dean	Smith,	Sr.		J	anuarv		11.00	
Examiner	4a Facility Neme (If not Institution, give s			4b. City	, Town, or Loca		4c. County o		
	10603 Bethel Ro	ad		F	rederic	k	Fred	lerick	
Funeral	5. Social Security Number 6. Sex			r 1 Year If Un		B. Date of Birth (Month, Day		Birthplace (State or Foreign Country)	
Director	219-82-4398	M 2□F 37	Yrs. Months	Days Hou	rs Min.	eb. 13		Maryland	
E 8 m	10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits	
The Maryans 28a-f show solffied at ector	Maryland Frederic	Erro	derick					1 ☐ Yes 2 ☒ No	
or 28a4 be notified	10e. Street and Number	1160		p Code			I Og. Citizen of Wi	net Country?	
A Paris	10603 Bethel Road	1		21702		1	Inited St	atas	
OF DE S		2. Wes Decedent Ever in U.S.	13. Was Dece		Origin? (Spec			- American Indian,	
hours after death with the Marya hours', or thems 23e or 28e4 sho at Examiner must be notified at od by Funeral Director	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		edent of Hispanic ecify Cuban, Mex 2 No Spec		ican, etc.)		White, etc. White	
ed within 72 hours atlygiene, we than "natural", or it, the Medical Exam. Completed by F	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's Usi (Give kind of w life. DO NOT	uel Occupation ork done during i use retired)	most of working	7	16b. Kind of Bus	iness/Industry	
2 10 4 (1	12		Roofer/Ca	arpenter			Constr	ruction	
d other arent, II	17. Father's Neme (First, Middle, Last)			18. M	other's Name (First, Middle,	Maiden Sumame)	
To B	Robert Leroy Smith	1		P	riscil]	La J. C	Carpenter		
12 should be file th and Mental Hy Tile marked othe Treatmetic event	19e. Informent's Neme/Reletionship (Typ		19b. Meiting Address	s (Street and Nu	mber or Rural	Route Numbe	r, City or Town, S	itete, Zip Code)	
2421	Donna L. Smith / W:	ife	10603 Bet1	nel Road	Frede	erick,	Maryland	1 21702	
D - 2 2 6	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Re	COT	pe of Disposition (Na netery, crematory or	other plece)	1	Dete	20c. Location - C	city or Town, State	
Pages ment of my or o	4 □ Donation 5 □ Other (Specify)		naven Memo	orial Ga	rdens	2000	Frederic	k, Maryland	
Departi Departiments any injusta	21. Signeture of Russeret Service License								
	23a, Pert1. Enter the disease, or complice shock, or heert failure. List only on	cations that caused the death.						Approximete	
Physician	snock, or neer failure. List only on	e cause on eech line.						Interval Between Onset and Death	
/Medical	Immediate Cause (Final	4 2 4	C F	. ~1. ~				2 11	
Examiner	disease or condition resulting in deeth)		2 years						
je let		Esopha		Cane				2 400.5	
buted amsir	Sequentially list conditions	7	a consequence of					a Jeans	
ificate be executed gphysician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury C.	7						14 200	
ficate be expression as the buria	thet initieted events	Due to (or e	s a consequence of)	:					
5 0 4 2	resulting in death) Last								
eath certific attending p	d								
deat deat	Pert It. Other aignificant conditions cont	ributing to death but not resulti	ng in the underlying	cause given in P	n in Pert I 23b. Did tobacco usa c			ributa to the cause of death?	
that the death cert led by the attendin deteched for use								3 Probably 47 Unknown	
or Attending Physician: The law requires that the death cereficated death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use ertification: To Be Completed by Physician/N						24a. Wes a	an autopsy med?	24b. Ware autopsy findings evailable prior to completion of cause of death?	
The Indiana						1 U Y	es 2000	1 ☐ Yes 2 ØNo	
entifica ector, p	25. Wes case referred to medical			26. P	lace of Deeth	(Check only or	ne)		
hysician: The law his certificate has t il director, page 2 s To Be Compl	examiner? 1 Yes 2 No	ospitel:	R/Outpatient 3 0	Other		,	ence 6 Other	(Specify)	
or Atending Physician: fire death. Director: After this certific in by the funeral director, artification: To Be (27. Menner of Death 1. Neturet 5 Pending 2 Accident investigation			28c. Injury at Work? 1 ☐ Yes	28		ow injury occurre		
To the Hospital or Attending Philipin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be determined	00 Discontinue Atheny for street feeting effice					itreet and Numbern, State)	r or Rural Route Number,	
To the Hospital of within 24 hours of To the Funeral Discompletely filled is Completely Call Cel	29a. Certifier (Check only one) 1 Certifying Physical Check only 2 Medical Examin	clan: To the best of my knowle er: On the basis of examinetion and menner steted.	edge, death occurred and/or investigation	d et the time, date n, in my opinion,	and place, en deeth occurred	d due to the d	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
Me of the	29b. Signeture end title of certifier		25	c. License numb	er		29d. Dete signed	(Month, Day, Year)	
F S F Ö	1×./>>>	m, mD		DY	186	6 3	anuary	3,2000	
	30. Name and address of person who cor Kanan Hudbad, MD		3a) (Type, Print) E AVENUE	F,FI	FREDE	zeck	(mo o	3,2000	
Chalc	31. Dete filed (Month, Day, Year)			·					
State Registrar	IAN 04	32. Registra/s Signetur	w B.	Som	61				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dev Month Year ROY EARL SMITH JANUARY 4, 2000 08:15 AM 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth CUMBERLAND If Under 24 Hrs. 8. Dete of Birth Hours Min. DEC 20 1 9 27 SACRED HEART HOSPITAL ALLEGANY 9. Birthplace (State or Foreign Country) MARY LAND 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year 6. Sex Days Months 1 ♥ M 2 □ F 212-24-0845 72 Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND ALLEGANY CRESAPTOWN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14721 OAKWOOD STREET 21502 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, Whita, etc. 1∑Yes 2☐No If Yes, Give 1 ☐ Never Merried 2€ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 1946-1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) KELLY SPRINGFIELD TIRE CO. MACHINIST 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) ROY EDGAR SMITH LILLIAN CHARLOTTE KUHN 19s. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DORIS G. SMITH WIFE 14721 OAKWOOD STREET CRESAPTOWN MARYLAND 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stete 4 Donetion 5 Dother (Specify) REST LAWN CEMETERY JAN 7 2000 LAVALE MARYLAND 22. Name end Address of Facility ature of Funeral Service Lici MERRITT-ADAMS FÚNERAL HOME d. 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 10 3 Probably 4 Unknown 24b. Were eutopsy findings svailable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Beath 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

À

Completed

88

21. Sig

1 PNaturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Funeral

Director

288-7

mant be r

8

Hygiens.

Pages 1 and 2 should be nent of Health and Mental

of Health as not if Health as vot of or other

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Examiner burial-transit pug physiclan Physician/Medlcai the 88 for use signed by the a Aq Completed has certificate Be Certification: To this

The lew requires that the death certificate be executed or Attending Physician: funeral director, After death. within 24 hours after deat To the Funeral Director: filled in by Hospital

1243

Medicai

State Registrar

impleted cause of death (Item 23a) (Type, Print) 30. Mame and address of person who oner

8 2000

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, State)

JANUARY 5.

Poad Cumberland MD 21502 925 Bishop Walsi

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner steted.

94

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

COUNTY TOOL IS WALL

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg.	No. 00 01250
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death	Day 2 2 Year 3. Time of Death
/Medical	Terry Lee Saville		2000 10 pm
Examiner	14214 Louise Drive Cresar		Allegany
Funeral Director	219-46-2350 XM 2DF 53 Yrs.	Min. Dec 7,	9. Birthpiace (State or Foreign
ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. toside City Limits
with the Marylar a or 28a-f show the notified at Director	MD Allegany Cresaptown		Yas 2□ No
th with the Ma 23e or 28a-f a ust be notified rei Director	10e. Street and Number 10f. Zip Code 2150		Citizen of What Country? USA
ours after death value, or items 234 Examiner mail	11. Marital Statua 1 Navar Marriad 1 Navar Marriad 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forcee? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin ff Yes, specify Cuban, Mexican, Find the Company of the	n? (Specify Yas or No- Puarto Rican, etc.)	14. Race - Amarican Indian, Black, White, etc. Specify:white
1 21215-0020 ed within 72 hours a vgiene. we than 'natural', or it, the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Work	of working	c. Kind of Businass/Industry
Ind 2 be filled v tal Hygie d other t event, th	17. Fathar's Nama (First, Middla, Last) 18. Mother's	s Name (First, Middle, Mail	
Maryland 32 should be fine h and Mental Hy 7 is marked othe traumatic event To Be C	*	ced J Eisle	
Mar d 2 sh d 2 sh d 2 sh d 7 is m	19a. Intormant's Name/Relationship (<i>Type, Print</i>) Juanita Saville 19b. Mailing Address (<i>Street end Number</i>) 14214 Louise Driv	or Rurel Route Number, Ci re; Cresapto	ity or Town, Steta, Zip Coda) DWn, MD 21502
altimore, mit. Pages 1 ar pertment of Hes y triury or other ss.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece)		c. Location - City or Town, Stata
ITHE ordered ordered ordered	4 □ Donation 5 □ Other (Specify) Restlawn Memorial Ga 21. Signature of Funeral Servica Licensee A 22. Name-and Adjirquis of Funelity		
D Ped Line	21. Signature of Funeral Servica Licensee		21502
	23a. Part 1. Entar the disease, or complications that caused the daath. Do not entar the mode of dying, such as ca shock, or heart tailure. List only one sause on each lina.		
Physician /Medical Examiner			Onsat and Death
executed n and ial-transit Examiner	Immediate Cause (Final disasse or condition resulting in death) a. Myocardial Infant paragraphic forms and the substitution of the substitution o	lar Disease	- 10 years
D, execu an and rial-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c		10 years
. BOX 68/60, death certificate be executed e attending physician and ed for use as the burial-transit sician/Medical Examir	Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of):		
BOX eath cert attendin for use		on pidasha	l death of
Phy the detache	Part II. Other stgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Frobably 4 Unknown
requir		24a. Was an a performed	
T 9 4 6 5		1 ☐ Yes	2 PNo 1 □ Yas 2 □ No
VITAL I	examiner?	ot Death (Check only ona)	
To the side of To	1 ☑ Yas 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs	sing Home 5 Residence	
Attending by death. ctor: After by the funerification:	27. Manner of Death 1 Natural 5 Pending (Month, Dey Year) 2 Accident investigation 28a. Date of Injury (Month, Dey Year) 28b. Time of thing thing work? 1 Yes 2 No.		nijaly occurred
2 94 5 E	3 Suicide 6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Stree City or Town, S	et end Number or Rural Route Number, Stete)
To the Hospital of within 24 hours a To the Funeral D completely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death and manner stated.		
To the comp	29b. Signature and title of cartifier 29c. Licansa number	29d.	. Data signed (Month, Day, Year)
5	Dog 1 mon Dog Dog 231		Jan 6, 2000
12/20	30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) Donald F. Manger M.D. 11600 Bedford Road N	NE. Cumber	land MD 21502
State	31. Date filed (Month Day, Year) 22. Registrar's Signature		

DHMH 16 Ray 6/95

Registrar

Shirt of Italy

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

\(\) Certificate of Death 2. Dete of Death 1. Decedent's Nama (First, Middla, Last) Month Year **Physician** Januara 4b. City, Town, or Location of Death 1027am Robert Wagner Sweigert 2000 02 /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F Days Months Hours Country) Maruland 215-20-7765 72 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28s-f show Washington Md. 1 Yas X No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20135 Landis Rd. Name 23s 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forces?
1∆ Yes 2 □ No If Yas, Give Year or Datas: 45-46 14. Race - American Indian, Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Wood Factory 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy.
Important: If Nem 27 is marked other any Injury or other traumatic event aloss. Be Luther B. Sweigert Mary J. Wagner 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Frances V. Sweigert (Wife) 20135 Landis Rd. Hagerstown, Md. 21740 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata burnel 2 Cremation 3 Removal from State Rose Hill Cemetery Jan 5,2000 Hagerstown, Md. 21. Signature of Funeral Service Ligensy 22. Nama and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disease, or complications that ceused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** tmmediata Causa (Final diseasa or condition resulting in death) /Medical In Broken Myocardia 30 minutes Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as e consequence of). 23b. Dtd tobacco use contribute to the cause of death? been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attanding Physicien: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Naturat To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 1.3.00 meland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

31. Data filed (Month)

Deiger

medical

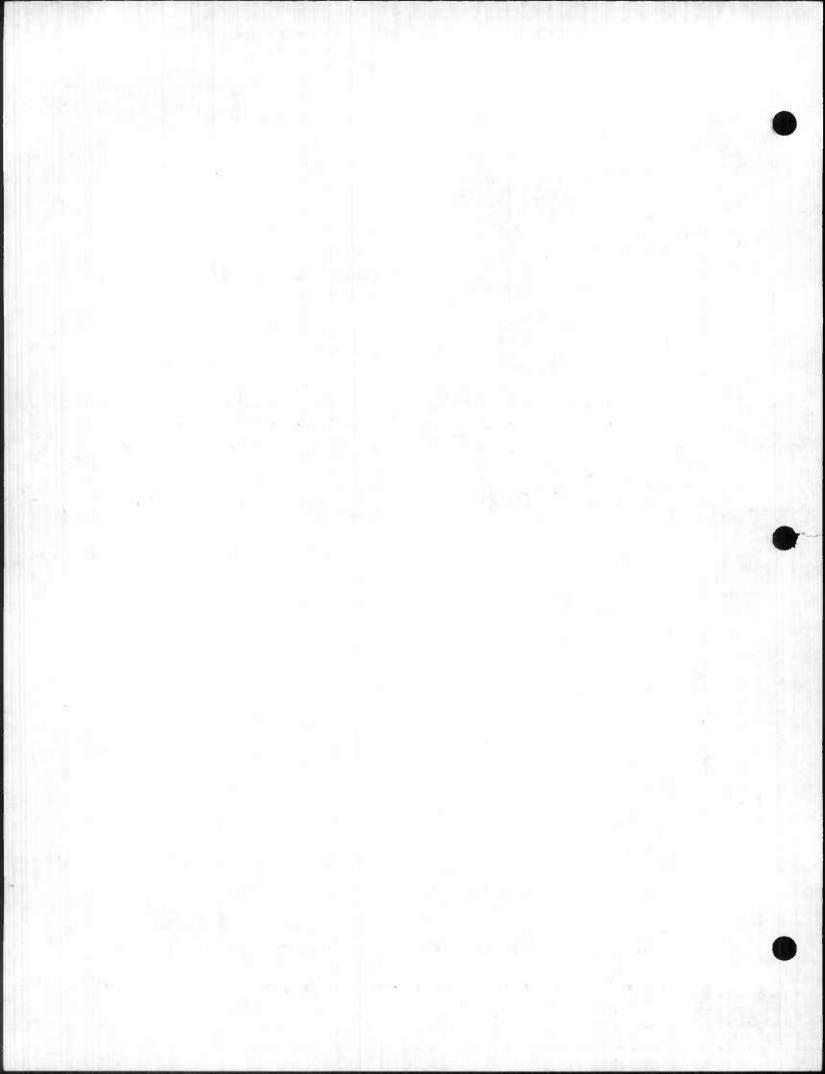
Campon

1/110

Begerstena MO. 21742

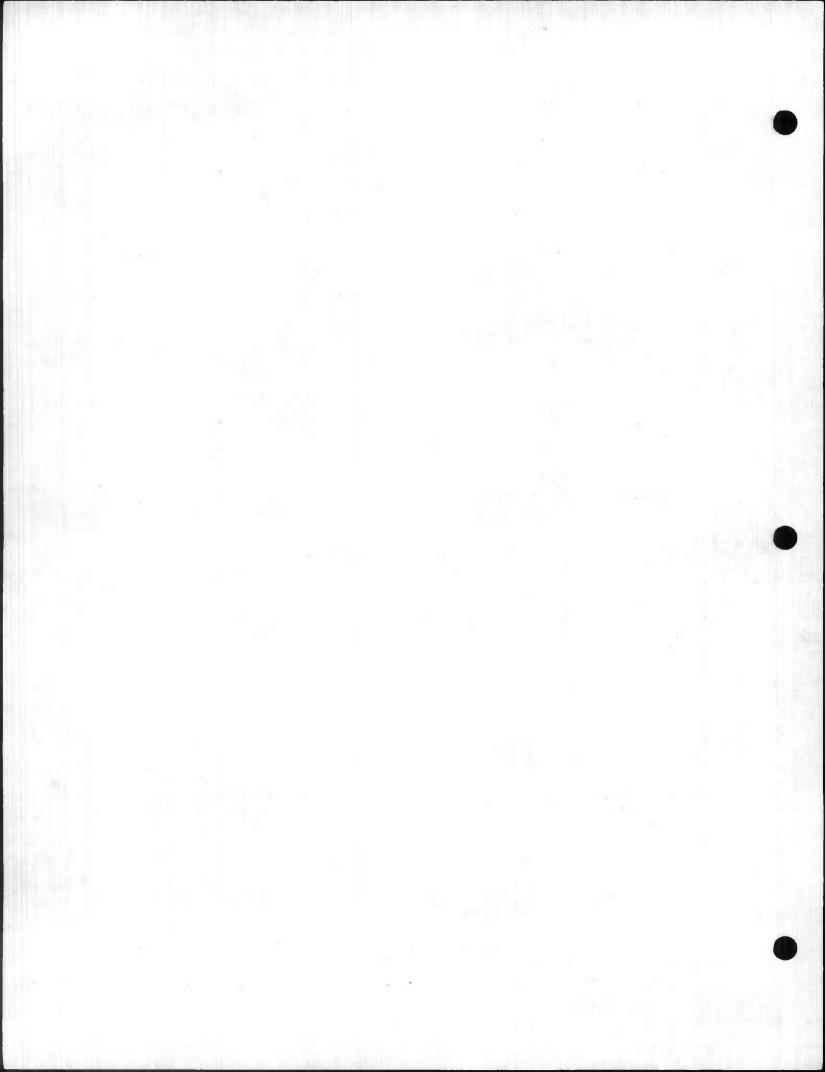
McCorneck

"0"3 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 252

			Cer	rtificat	e of	Death		Reg. No	٥.		I have by his
	1. Decedent's Name (First, Middle, La	nst)					2. Data o Month	Death			3. Tima of De
Physician	ATICO MORIO SA	Alice Marie Sheeley						De Camilla de S		Year	230/
/Medica	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location							ary o	. County	Of Death	L /
Examine							stown	40		hings	tan
144	Washington Cou		4	If Under	1 Voor	If Under 24		51.4			
Funeral		Sex 7. Age (In yrs	. last birthday) Yrs.	Months	Days		Min. Data of	Birth Year	311		ace (State or F
Director	215-14-0565	38	112.				vec.	20,17	741	reni	wyevun
p .	Usual Residence of Decedent 10a. State 10b. County	100 C	She Tour as La	antion							ad accide dive
de de la	11.1	ington	ity, Town or Lo	Smit	-behe	i k o				10	ld. Inside City L
The Management of the Manageme	Ma. wasne	ngron		SIILL	riouu	vig					Val vas 2
off the Ma to 28a-f s be notified	10e. Street and Number			10f. Zip				10g. Ci	tizen of V	Vhat Count	ry?
		t.			217	83			u.s.	A.	
ther death v r items 23s niner, mant	11. Marital Status	12. Was Decedent Ever in U	U,S. 13. V	Was Deced	dent of H	ispanic Origin	n? (Specify Yes o Puerto Rican, etc.	No-		e - America	
d 2 should be filed within 72 hours after th and Mantal Hyglene. T is marked other than "natural, or its traumatic event, the Medical Ensimine	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No					Puerto Hican, etc.	,		k, Whita, a	
72 hours after netural, or it disal Examin	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes	2 L)(No	Specify:		specity: White			te
of the P	15. Decedent's E	ducation	16a. Deced	dent's Usua	al Occup	ation		16b. K	Cind of Bu	sinass/Ind	ustry
ad within 72 ho tyglene. Wer than "naturn ft, the Medical.	(Specify only highest gro		(Give	kind of wo	rk done d	during most o	f working				
Tage a	Elementary/Secondary (0-12)	College (1-4or 5+)			nemai			1	Home		
The state of	17. Father's Name (First, Middle, Last	el					Name (First, Mic	Idla Maida	Sumam	a)	
	7-1 4 01 0-	y					rel E. P.		Jumain	10)	
marked marked			1			LAI	Let L. T	Jyue			
ealth and Menta in 27 is marked her traumatic e	19a. Informant's Name/Relationship (or Rural Route N			State, Zip	Code)
# 27 H	Sara A. Sheeley 1	Sister)	P.O.	Box	84 5	Smiths	ourg, Md.	21783	5		
五百名	20a. Method of Disposition		Place of Dispo-	sition (Nam	ne of	sel	Data	20c. L	ocation -	City or Tov	vn, Stata
7 11 10	Burnel 2 Cremetion 3 Donnelson 5 Other (Special	Planoval from State					1. 6,200	Smi	ithat	ura. N	Ad.
원 등 등						_	1	1			
Depart meorts any inj 2008	22. Name and Address of Facility Davis Funeral Home Smithshura Md 21783										
	Silverio Sureg, inc. 27700										
	23a. Part1. Enter the disease, or com- shock or heart failure. List only	oplications that caused the des	ith. Do not ente	er the mod	le of dyin	g, such as ca	ardiac or respirato	ry arrast,			Approximata Interval Batwee
hysician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximation and the mode of dying, such as cardiac or respiratory arrast, interval Ba Onset and										Onset and Dea
/Medical	Immediate Cause (Final disease or condition	6.1	netrie	- 1	1						T 1
xaminer	resulting in death)		or as a conseq		im	<u> </u>		_		1	Tyes
		Dua to ((or as a conseq	dence ory.							
The state of	C	b	·								
- Interest	Sequentially list conditions, if any, leading to immediate	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
bud a	Cause (Disease or injury that initiated events	Cause (Disease or injury c.									
ing physician and a as the buriet-transit	resulting in death) Last	that initiated events									
9		d								1	
for us										1	
the d	Part It. Other significant conditions of	contributing to death but not re	sulting in the ur	nderlying c	ause giv	en in Part I.	23b.	Did tobacco	o use cor	ntributa to	the cause of d
5 . 5								Yes :	2 No	3 Prob	ebly 4 Un
be de							_				
S P P							24a. \	Vas an auto erformed?	psy	24b. We	re autopsy find ilable prior to
should bluods							_	enonnedr		con	npletion of caus
pe 2									-		
age of								☐ Yes 2	No	1	Yes 2 No
		Hospital:			011		Death (Check o	nly one)			
e d	1 Yes 2 No	1 Minpatient 2L	ER/Outpatien			4 Nors	ing Home 5 🗆 f)
	27. Mannet of Death 1 ☑Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	2	8c. Injun Worl	k?	28d. Descr	ibe how inju	iry occurr	red	
the fo	2 Accident investigation		10.17	М	1 🗆	Yes 2 No					
Director: After	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At I	nome, farm, stre	eet, factory	, office		28f. Locati	ion (Street and Number or Rural Routa Number, or Town, Stata)			
- F	4 Nomicos	4 ☐ Homicide 4 ☐ Homicide					City of	TOWN, Stat	α)		
To the Funeral Dir completely filled in Madical Cart		hysician: To the best of my kn	owledge death	occurred	at the tin	ne date and s	place and due to	the cause/s	s) and ma	nner as st	nted
pletaly file	(Check only 2 Medical Exam	miner: On the basis of examina	ation and/or inv	restigation	in my o	pinion, death	occurred at the ti	me, date an	id place, i	and due to	the cause(s)
To the Funeral Completely filled		and manner stated.		200	Linana			204 0	nto cione	d Manth C	Day Maasl
28	29b. Signature and title of certifier			290		e number		290. UE	ita signec	d (Month, E	Day, Tear)
	Muchael J.	Milonal	MA		00	1166	7	1	. 3 .	00	
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, I	Print)			,				
	30. Name and address of person who Michael T. M 31. Data filed (Month, Day, Year)	helocare	1/110	No 1	ical	16m-	21	14	rer.	to.	no >
State	31. Data filed (Morith, Day, Year)	32. Begistrar's Sier	eture 4	1	200	ومرم	00	///	10171		1.0.0
State Registrar	31. Data filed (Month, Day, Year) JAN 03 20	100	ature J.	140	ack.	2					

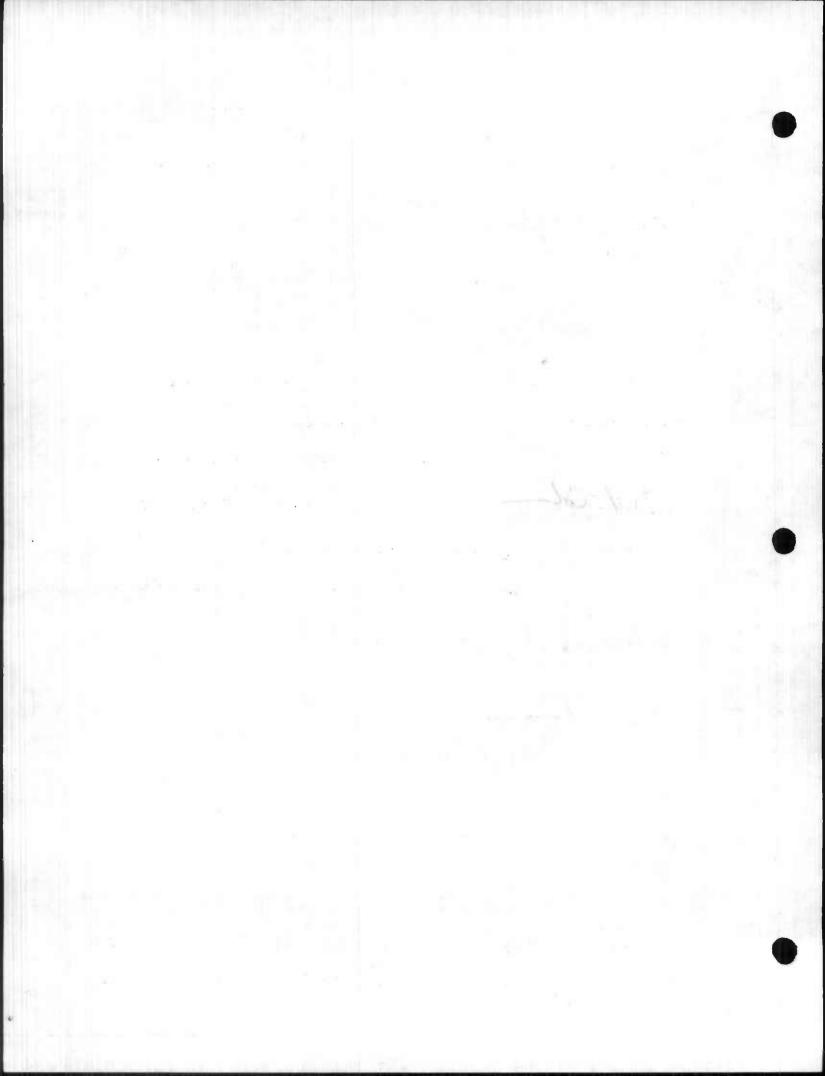


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 2000 Doris Mae Showe January 5:20 am /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner 15647 Clear Spring Road Williamsport Washington 8. Dete of Birth (Month, Day, Year) Feb. 27, 1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary land 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XXF Days Months Hours Yrs. 219-14-8651 76 Director Usual Residence of Deceden the Manyland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits y 28a-f show a notified at 1 Yes 2(XNo Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? ŏ 21795 USA Berns 23a 15647 Clear Spring Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 72 hours after 1 □ Never Married 2 □ Married Specify: White 'natural', or Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hyglens. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic sound 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Chester Worthington Della M . Myers 19a. tnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 15647 Clear Spring Road Williamsport, MD 21795 Debra Oliver / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other plece) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donelion 5 ☐ Other (Specify) 1-7-00 Greenlawn Memorial Park Williamsport.Maryland 21. Signetura of Funerel Service Licensee 22. Name and Address of Facility
Osborne Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate Approximete Intervei Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition rasulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner el Cara physician and the burlet-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or trijury that initieled events rasulting in death) Last Box 68760. Due to (or as e consequence of) 188 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ The law requires 24b. Were europsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2000 1 ☐ Yes 2 Do of Vital 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funera 27. Manner of Death 28c. Injury at 28d. Dascribe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and fitte of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) TANVIR A. MSHA 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 05 Physician Catherine Smith 2000 AM JOIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Franklin Woods Genesis Eldercare Rosedale Baltimore H Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth Months Days Hours Min. April 1 Day (State or Foreign Country)

April 1 Day (State or Foreign Country) 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1□ M 2×F Months Days 298-22-4876 Yrs 76 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Directo MD Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1752 Brookside Drive 21040 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puarto Ricen, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or its 1 □ Navar Married 2 □ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) In home 12 Homemaker 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Catherine Jones James Lee Robinson 19a, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straet end Number or Rurel Route Number, City or Town, State, Zip Code) 353 Candler St., N.E., Atlanta, GA 30307 Barbara A. Robinson (Daughter) Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1/7/00 any injury or o Buriat 2 Cramation 3 Removal from State Aberdeen, Maryland St. Paul's Lutheran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Fuperal Service Licensee Aberdeen, Maryland 21001-33

23a. Part1. Enter the disease, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, ahock, or heart failure. List only one causa on each jule. Aberdeen, Maryland 21001-3399 Approximata Intarval Batwaan Onset end Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in deeth) 30 minutes Hypoxemia Examiner Dua to (or as e consequence of): Physician/Medical Examiner Henrt 2 weeks ongestive certificate be axecuted inding physician and use as the burial-transit Qua to (or as a consequence of) Sequentially list conditions, if any, leeding to Immediata causa. Entar Undarlying Cause (Disease or Injury that initiated avents resulting in death) Last Box 68760, Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 30 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Morbid Obesitu þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificata Physician: 25. Was casa referred to medical exeminar? Be 26. Place of Death (Check only one) Hospitat: Other: 45 Nursing Home 5 Rasidence 6 Other (Specify) 10 1 Yes 25 No 1 Inpatiant 2 ER/Outpatlant 3 DOA After this 28e. Date of Injury (Month, Dey Year) uneral 28d. Describe how Injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 3 T Suicida 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homlcide Hospital 29a. Cartifia: t 🛣 Certifying Phyaician: To tha bast of my knowledge, deeth occurred at the tima, data and place, end due to the causa(s) and mannar as atated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c, License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla di certifiei D53462 00 MD 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 10 FAllston, MD # 9 Pelair Road

DHMH 16 Rev 6/95

State

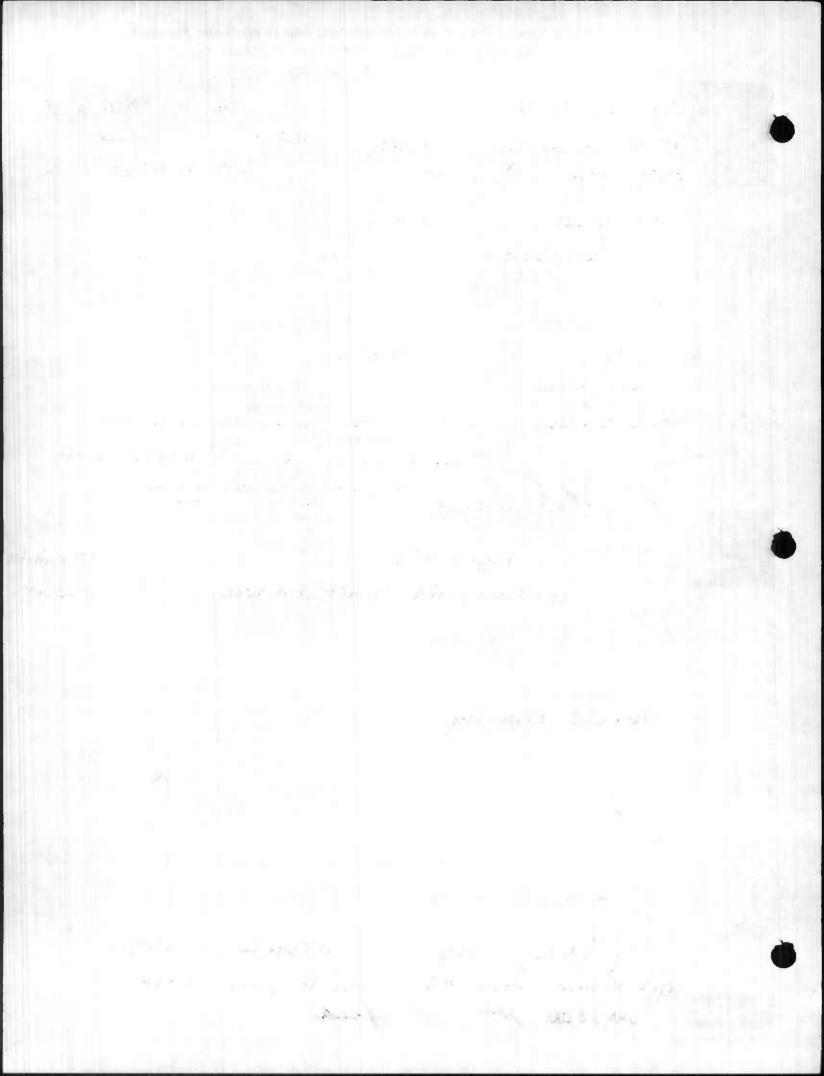
Registrar

2112

31. Data filed (Month, Dey, Yeer)

JAN 0 6 2000

Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Dhusisian	
Physician / Medical	
Examiner	ı
	ı

1. Decedent's Name (First, Middle, Last)

2. Date of Death

3. Tima of Death 10:44 AM

4 Unknown

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JANUARY

21502

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

attending physician and for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the page 2 should be detached Certificat

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Registrar

HERMAN	ELMER S	HAWVER						4	JANUAR	Y 7°	200	Year	10:44	AM
4a Facility Name (If I	not institution, give HEART HOS		iber)				CUMB	ERLAI	cation of De		County of		Z	
5. Social Security Nu 232-54-4	4237	M 2 F	7. Age (In yrs. 66		If Under Months	Days	If Under Hours		8. Date of E (Month,) NOV •	Birth Pay, Year) 17,19.	33 W	9. Birth	vince (State	or Foreign
Usual Residence of D 10a. Stete WV	10b. County MTNERA	L		y, Town or Loo ORT ASH									10d. Inside (City Limits
10e. Street and Num	ber PTS RO	OUTE 28			10f. Zip	6719			- 40		zen of W	hat Cou	ntry?	
11. Maritel Stetus To Never Marrie 3 Widowed 4	d 2 Married	12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No	11	Vas Dece i Yes, spe	cify Cub	lispanic Or en, Mexica Specify:	n, Puerto	ecify Yes or f Rican, etc.)	No-		, White,		
	15. Decedent's Ed by only highest grad dary (0-12)		4or 5+)	life. L		ork done ise retire	during mos d)	st of worki	ing	WV S	nd of Bus CHOC BLIN	L F	dustry OR DEA	Æ
17. Father's Neme (F	First, Middle, Last) SHAWVEF	₹		1100	0.0		18. Moth		(First, Midd	lle, Maiden	Sumame)		
21. Signature of Fundamental 23e. Part1. Enter the shock, or heert	disease, or confe vailure. List only	Characteristics that can	used the deat	h. Do not ente	Name ar UPCHI P.O.I	nd Addre URCH BOX de ot dyir	1260- ng, such as	RAL FORT		, WV arrest,	2671		Approxima Interval Be Onset and	neewte
Immediate Ceuse (F disease or condition resulting in death) Sequentielly list condition and list condition cause. Enter Under Cause (Disease or in that Intitated events resulting in death) List.	ditions, nediete ying ijury	b	Due to (c	or as a consequence a conseque	uence of):	•	ial.	inge	anetia	1			7511	ymil)
Part II. Other algnific	ant conditions co	d	ath but not res	ulting in the ur	nderlying o	cause gh	ven in Part	î.	24a. W. pe	as an autoperformed?	□ No	3 Pro	Vere autopsy vailable prior ompletion of death?	Unknow findings
25. Was case referre	·	Hospital:	· · · · · · · · · · · · · · · · · · ·	/		OA Ott	er.		h (Check on)	y one)				
27. Manufer of Death	5 Pending Investigation	28a. Date o		28b. Time of injury		28c. Injui Wo	4 🗆 🖂		me 5 Re 28d. Describ				ly)	

Mes

Medical

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Richard Schmitt, M.D.

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homlcide

29b. Signature and title of certifier

- 900 Seton Drive, Cumberland, MD

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

32. Registrer's Signeture

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

D26333

29c. License number

ANI LENG from & April

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

01256

			STEIL	DING							2. Date of D Month Janua	Day	Year 2000	3. Time of Death 7:30 am		
	Name (If not instituti	ion, give s	treet and no	umber)					4b. City, To	wn, or Lo	cation of Dea	-	unty of Death			
	orial Hos	pita]	L						Cum	ber	and	A	llegan	17		
	curity Number	8. Sex		7. Age (In yrs. last bir	thday)	ff Under Months	1 Year Days	If Under		R Date of Bi	eth	9. Birth	nplace (State or Foreig		
	18-8058	10	M ¾ □F	83	3	Yrs.	MOIIII	Days	riouis	PAIR L.	JAN 5	,1917	MARY	LAND		
10a. State	ence of Decedent 10b. Coun	ly		1	Oc. City, Tow	n or Loc	ation							10d. Inside City Limits		
MD	ALI	EGAN	Y		CUMBE	RLA	ND						= 7	1 XYes 2 N		
10e. Street	and Number						10f. Zip	Code				10g. Citizer	of What Cou	untry?		
107	LUTEMAN F	OAD					21502						10g. Citizen of What Country? U.S.A.			
11. Marital S	Status	1	2. Wes Dec	pedent Eve	er in U,S.	13. W	les Deced	lent of H	lispanic Ori	gin? (Spi	ecify Yes or N Rican, etc.)					
1 Nev	er Married 2 Me	rried	Armed F	2 □ No						i, Puerto	HICAN, etc.)					
3 Wid	owed 4 Divorce	d	Year or I	Detes:		1 ☐ Yes 2 ☐ No Specify:						Specity: WHI'				
	15. Decede)	16a.	16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)							of Business/li			
Elementa	ry/Secondary (0-12)	T		(1-4or 5+)		SOCIAL WORKER						DEPT. OF HUMAN				
47 Esthada	Name (First, Middle	1 0001	4									STATE OF MARYLAND				
	UR P. DIX					ELLEN M. D.						First, Middle, Maiden Sumame)				
	ant's Name/Relation		ne Print)		10h	19b. Meiling Address (Street and Number or Rural Rou										
	N OSMANSK		12.5	TER		9b. Meiling Address (Street and Number or Rural Rou 307 LOUISIANA AVE., CUMBI								_		
20a. Method	of Disposition				20b. Plece of				an)	T	Date	20c. Local	ion - City or 1	Town, Stete		
	ial 2 Cremation		emovel from	Stete	HILLCF	LLCREST BURIAL PARK 1/10/0							RLAND,	, MD		
	re of Funeral Service		0,0			22.										
1	Thandy	6	4.00	hu	11						IOME, P		2150	12		
23a. Pert1.	Enler the disease,	or complic	alions thet	caused the	e death. Do r	not ente	r the mod	e of dyir	ig, such as	cardiac o	MBERLA or respiretory	intest,	2150	Approximata		
shock	or heart leilure. Li	st only on	e cause on	eech line.									i	Onsel and Death		
Immediate	Immediate Cause (Finel disease or condition action in deathlion in deathlion in deathlion is deathlion.												1	15 YRS		
disease or condition resulting in death) Due to (or es a consequence of):												13 1163				
Due to (or es a consequence of):																
Sequentially list conditions, if any, leading to immediate cause. Finer Underlying																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):																
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											1					
	resulting in death) Last															
											1		1			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of d													11/2/11/20/20 20 20 20/20/			
											1,8	Yee 201	No 3□Pr	obably 4 ☐ Unknow		
											24a. We	s an autopsy	24b. V	Vere autopsy findings		
											perl	ormed?	C	vailable prior to completion of cause of death?		
												V 01/10				
25 Was car	e referred to medic	al I							00 0			Yes 2	10	Yes 2 No		
examine	(1)		ospitel:	Inpatient	2□ER/Ou	444	a 🗆 200	Oth	uner-		(Check only		70th an /00 and			
27. Manner			28a. Date	of Injury	28b. 7	ime of		Bc. Injur			me 5 Res 28d. Describe			ату)		
1, Nett	1	ing tigation	(Mor	nth, Day Y	'ear) l	njury	м		k? Yes 2 🔲 I	No						
3 ☐ Sui	cide 6 Couk	not be	28e. Plac	e of Injury	- At home, fe	rm, stre	et, lactory	, office		-	28f. Location	(Street and N	lumber or Au	ral Route Number,		
4 Homicide determined determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)											City or 10	iwn, Stete)				
29a. Certifie (Check one)	only 2 Medica	ing Physi I Examin	er: On the b	e best of m asis of ex	camination and	, death d/or inve	occurred a estigation,	nt the tir in my o	ne, date an pinion, deel	d place, th occum	and due to the ed at the time	cause(s) en , date and pla	d manner as ace, and due	stated. to the cause(s)		
29b. Signature and title of cegtifier 29c. License number 29d. Date signed (Month, Day, Year)											n, Day, Year)					
18 James 1 MO D14865										Innu	- an	2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									2000							
31. Date file	Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502 31. Date filed (Mary) Cay, Year)															
	31. Date filed Mann 1 2000 32 Flegistrar's Signature & Apocks															

ANTI SON James & Separate

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Allan Treese January Døy, Kevin 2000 9:20 A.M. 4a Facility Name (# oot institution, give street and number)
Frederick Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Frederick 7. Age (In yrs. last birthday) Hours Min. Feb. 23, Year 70 If Under 1 Year 5. Social Security Number 271-66-2022 9. Birthplace (State or Foreign Days Months Pennsylvania NOM 20 F **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g, Citizen of Whel Country? 7125 Autum Leaf Lane 21702 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1

Never Married 2

Married White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never worked 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) Patrick Allan Treese Dawn Klug 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7125 Autum Leaf Lane, Frederick, Md. 21702 19a. Informant'a Name/Relationship (Type, Print)
Patrick A. Treese/Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Jan. 8, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Fecility Keeney & Basford Funeral Home M00021 106 East Church Street, Frederick, Md. 23a. Part1. Enter the disease, or complications that drused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Duchenne's Muscular Distrophy Immediate Cause (Final 20 Years disease or condition resulting in death) Due to (or es a consequence of): Cardiac Arrest Due to (or as a consequence of): Pulmonary Arrest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

strending physician and for use as the burlet-transit

signed by the e

should

has page 2

certificata

this

After

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun

funeral director,

or Attending Physician:

by

Completed

8

Certification: To

edical

The lew requires that the deeth certificate be executed

Box 68760.

Division of Vital Records, P.O.

Department in important if eny injury or pose.

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

2

Funeral

Director

28e-f

mast be r

other than "natural", or the

. Pages 1 and 2 should be filed w timent of Health and Mental Hygler tants if them 27 is marked other th jury or other traumatic event, that

with the Mandand

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

31. Date filed (Month, Day, Year)

JAN 0 7 2000

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending

1. ZiNatural 2 Accident investigation 1 Yes 2 No 3 Suicide 6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s). 29a. Certifier niner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel

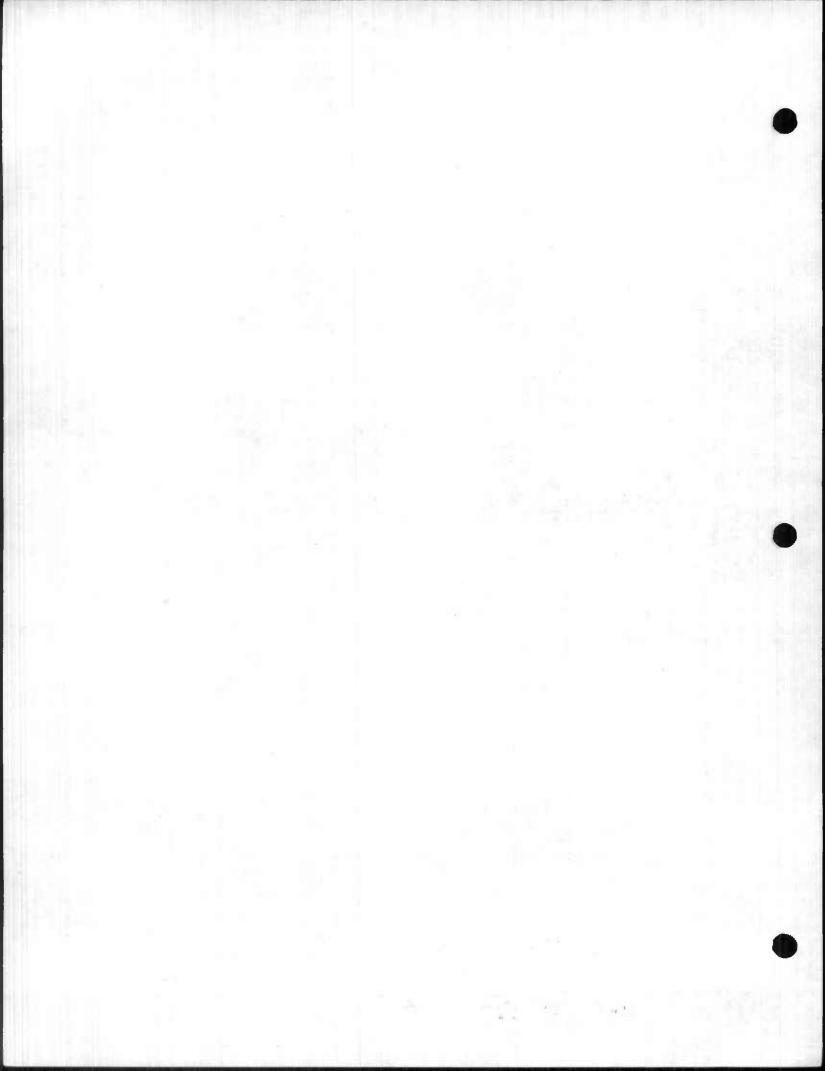
29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D26609 January 6, 2000

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

Joseph Ashwal, M.D., 56 Thomas Johnson Drive, Frederick, Md. 21702

State Registrar

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:45 pm J.C. TAYLOR 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE 6. Sex, 1 M 2 □ F 7. Age (In yrs. last birthdey) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months 218-32-9302 Usual Residence of Deceden Sept. 28, 1936 Virginia 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Cecil Port Deposit 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21904 49 Orchard Dr. USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 □Xes 2□No If Yes, Give Yeer or Detes: Peacetime 1 Never Married 2 Merried 1 Yes 212 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Clarence William Taylor Sarah Jane Hensley 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Beulah Taylor / Wife 49 Orchard Dr., Port Deposit, MD 21904 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 XBurial / 2 Crematig 1-4-00 fon 5 00 Darlington, Maryland Dublin Missionary Bapt. Cem. 21. Signature of Funeral S 22. Name end Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 E. o. complete than the claused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Interval Between Onset and Death myocardial infarction Immediate Cause (Final disease or condition resulting in death) Sepsis Sequantielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yea 2 ☐ No 25. Was case reterred to medical axaminar? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

The law requires that the death certificate be executed Box 68760. the o signed by the 9 Records, certificate has of Vital Attanding Physician: this funeral After Division death. 24 hours after deat Funeral Director:

Examiner Physician/Medical þ Completed Be Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

mast be notified at

Nems

8

'natural',

Hygiene.

Pages 1 and 2 should be finent of Health and Mental I tem 27 is marked of

Department of Important: If any injury or 三古

Physician

/Medical **Examiner**

945

with

filed within 72 hours after

21215-0020

Maryland

Baltimore,

Director

Funeral

ρ

Completed

2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier

(Check only one)

6 Could not be datarmined

28a. Date of tnjury (Month, Dey Year) 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner steted.

BALTIMORE, MO

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Cut wenders my Resident

29c. License number

29d. Date signed (Month, Day, Year) 00

30. Neme and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

22 South WEHBERG M.A. 2000 32. Registres Signature

GREENE STREET

State Registrar

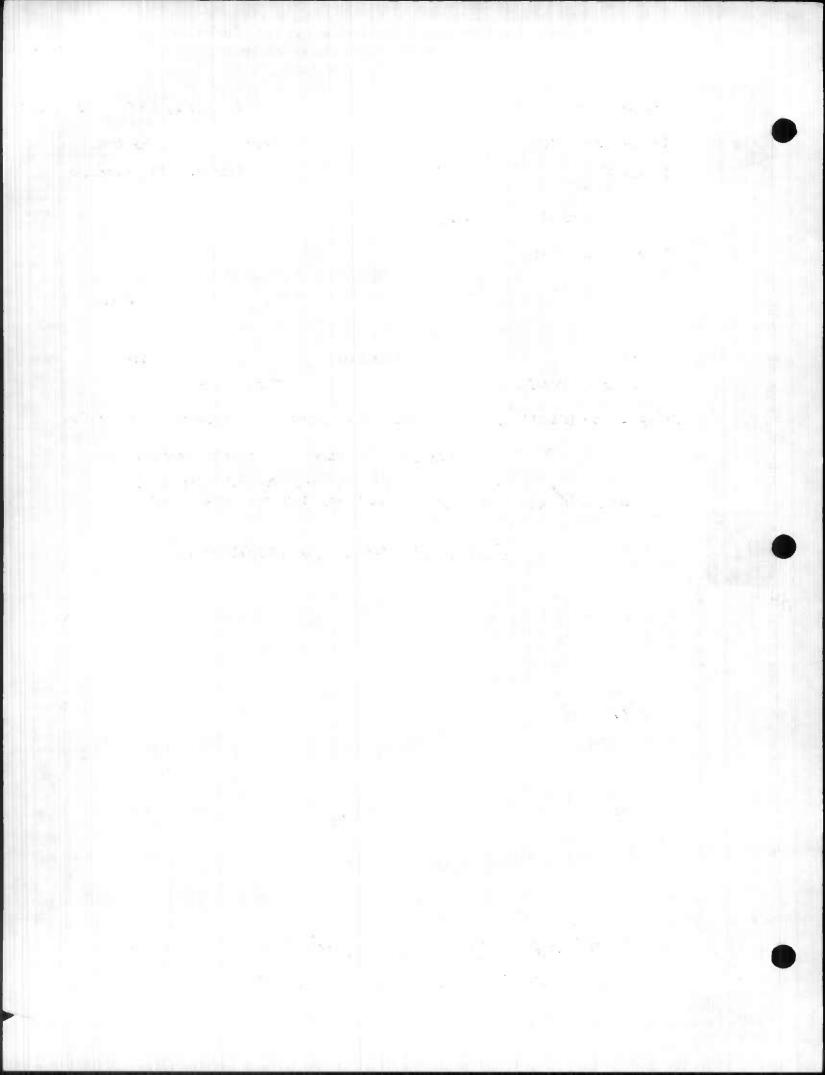
within 2

8 Hospital

10+1

State of Maryland / Department of Health and Mental Hygiene 1 1 2 5 9

				Cer	tificate of	Death	R	eg. No.		1 60 61 01		
		1. Decedent's Neme (First, Middle, La	st)				2. Date of Dea		Mana	3. Time of Death		
	Physician	Wanda Lee	True				January	Day 200	Year	12:19 P.M.		
A	/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)			4b. City, Town, or Lo		4c. County		12019 2 111		
A	LAdilitie	510 Baltimore Co	irt			Aberdee	2	U-	arfor	a		
-	Funeral	5. Sociel Security Number 6. S		st birthday)	If Under 1 Yee	r If Under 24 Hrs.	8. Date of Birth (Month, Day			lace (State or Foreign		
	Director	216-22-7286	□M 212 F 72	Yrs.	Months Days	Hours Min.	June 8,	land				
	P.	Usual Residence of Decedent	40- 04	T					Ta	0.4 ft. 1.4 @th. 41 h		
	show de t	10a. State 10b. County		Town or Loc	SATION				1	0d. fnside City Limits [X☐ Yes 2 ☐ No		
	Serie M	MD Harford	d Aberd	leen								
	iter deeth with the Me r terms 23a or 28a-fe ine must be notified Funeral Director	10e. Street and Number 510 Baltimore Con	urt		10f. Zip Code 210	01	1	try?				
	dee dee	11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	3. 13. V	Ves Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ck, White,			
21215-0020	urs e	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2010 If Yes, Give Year or Dates:		☐ Yes 為 No				White			
5-0	ed within 72 ho ygiene. her than "neturn rt, the Medical Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give I	ent's Usual Occu	a during most of work	ing	g 16b. Kind of Busine		dustry		
121	Man Man	Elementery/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retir	9d)						
	be filed within that Hygiene. Id other then event, the M	17. Father's Neme (First, Middle, Last,		Н	omemaker	10 Mothodo Nom	In ho		ome			
Maryland	Sab W	Isaac H. Cra					C. Bea					
	C1 00 00 00	19e. Informant's Name/Reletionship (Sandy Morgan (Dat			g Address (Street 2 East 4	of and Number or Run 3rd St.		ula, Oh.	Code) 14004			
altimore,	8 = 2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specif	Removel from State	metery, crem	sition (Name of natory or other pl Cemete	aca) ry 1	1-1	20c. Location Geneva,	, Ohio			
alti	Department Department Important: any injury	21. Signature of Funeret Service Licer	- D 7									
ä	Departimon any irr	1 1	RO	4	_	Cargo Fune						
-		23a. Pm1. Enter the disease, or com	plications that caused the death.			, Maryland				Approximate		
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting In death) a. OVARIAN CA with MUTASTASIS Due to (or as a consequenca of): Due to (or es a consequenca of): Due to (or es a consequenca of): C. Due to (or es a consequenca of): Due to (or es a consequenca of): Due to (or es a consequenca of): Due to (or es a consequenca of):										
68760, 7	death certificate be executed attending physician and of or use as the bunal-transit sician/Medical Examir											
×	6 50	resulting In death) Lest	Due to (or es e consequence of):									
Bo	d for icia	Part II. Other significant conditions of	ontributing to death but not recul	ting in the up	23h Did t/	the cause of death?						
P.0	the by the ache	- A14 11 A	ontrouting to death out not resul	ang an are ur	loelly lig cause g	went in Fatti.	23b. Did tobacco use contribute to the cause of					
	5 50	TINEMIA										
Records,	been shou	- HTN.					24a. Wes a perfor		av	ere autopsy findings alleble prior to mpletion of cause death?		
	The law page 2						1 🗆 Y	es 200 No		Yes 207No		
ta	certificate rector, pag	25. Was case referred to medical				26. Place of Deal				3100 2010		
of Vital		examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatien	t 3□ DOA C	ther:	ome 5 Resid		ner /Snecif	(v)		
	Phys rthis aral d	27. Menger of Death		28b. Time of	28c. Inj		28d. Describe h			y/		
on	ding th. Afta	Natural 5 Pending 2 Accident Investigation		Injury		ork? ☐ Yes 2 ☐ No						
Division	tal or Attending P rs after death. el Director: After t led in by the funers Certification:	3 Sulcide 6 Could not b	28e. Placa of Injury - At hor building, etc. (Specify)	ne, farm, stre	28f. Location (S City or Tow		ber or Rura	I Route Number,				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 7	29a. Certifier Certifying Ph	ysician: To the best of my know ninar: On the basis of examination	ledge, death on end/or inv	occurred at the restigetion, in my	time, date and placa, opinion, death occur	and due to the cred at the time, c	ause(s) and m late end pleca,	anner as s	tated. o the cause(s)		
	ithin ithin on the on the on the on the on the on the one of the o	29b. Signature and title of cartilles 29d. Date signed (Month, Day, Year)										
	F 3 F 8	1/1/1	1 1) Ilalon								
	/	11/000	10	1117	00							
	5	30. Name and eddress of person who	completed cause of deeth (Item	5, 0	WION!	gut HO	16, M	1 210	298	1		
	State Registrar	31. Date filed (Month, Day, Year) JAN 03 2	32. Registrar's Signatu	G.	Loca	161		/				

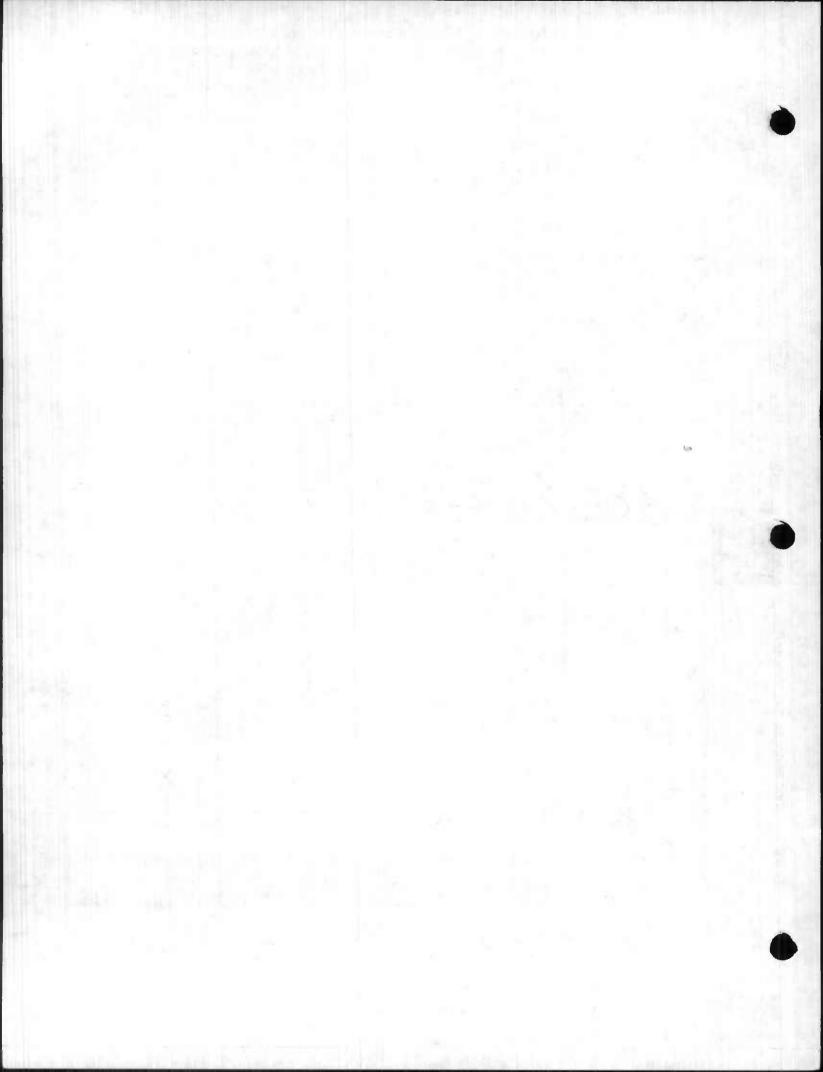


State of Maryland / Department of Health and Mental Hygiene 00 01260

					Cert	ificate of	Death		Re	g. No.		7 110		
		1. Decedent's Nema (First, Middle	e, Last)	77.7					2. Date of Death		Vana	3. Tima o	Deeth	
Physici			ROBERT I	EDWARD 1	WEDDL	E, JR.			Month January	1, 200	Year)0	7:20)PM	
/Medic Examir		4a Facility Name (If not institution					4b. City, To		ation of Death	4c. County	of Death			
•		Frederick Memor	ial Hospital	1			Fred	erick		Fred	leric	k		
Funeral Director		5. Social Security Number 217–28–6541		ge (In yrs. lest i	Yrs.	if Undar 1 Yaar Months Deys		24 Hrs. Min.	8. Dete of Birth (Month, Day, June 27	Year) 1935	Coun	laca (Stete try) Land	or Foreign	
pu .		Usuel Rasidence of Decedent 10a, State 10b, County		10c. City, To	own or Loc	ation					10	Od. Inside C	Ity Limits	
death with the Meryland frms 23e or 28e-f show ir mast be notified at	tor		erick		erick								2 No	
r 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Coun	try?		
3a o	0	9305 White Roc	k Avenue			21	702			U.S	S.A.			
한 포함	by Funeral	11. Mentel Stetus 1 Never Married 2 Mem 3 Widowed 4 Noivorced	12. Wes Decedent Armed Forces' ied 1 ☐ Yes 2X If Yas, Give Yaer or Detes:	? No		as Decedent of Yas, specify Cut			to Rican, atc.)		Raca - Amarican Indien, Bleck, White, etc.			
d within 72 hours at glene. Ir then "natural", or the Medical Exercises	Pa	15. Deceden			Sa. Decede	ent's Usual Occu	petion		16b, Kind of Businass/Inc				1	
Z un Z	Completed	(Specify only highes	st grada completed)		(Give k	ind of work done O NOT use retire	during mos	st of workin	working					
within lene. then	E	Elementery/Secondery (0-12) 12	College (1-4or	5+)	Ne	wspaper	Carr	ier	Fred. News Post					
should be filed ad Mental Hygi marked other imatic event, it	Be C	17. Fathar's Nama (First, Middla,	Last)						(First, Middle, Meiden Sumeme)					
id be ental	To B	Robert E. Wedd	le, Sr.				Paup	a Ada	line Gu	е				
2 4 4	n 27 le	19e. tnforment's Neme/Relationship (Type, Print) Melanie S. Burns (Daughter) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, 13826 Rockford Court, Woodbridge, VA 221											E	
EZNL		20e. Method of Disposition	o (baagneer			ition (Neme of		1		0c. Location -				
8 7 2 0		1 Burial 2 Cremetion		ceme	tery, crem	elory or other ple 3 Cremat		1/	5/2000				land	
Physician /Medical Examiner	niner	23a. Pert T. Enter the disease, or shock, or heart failure. List Immediata Causa (Final disease or condition resulting in deeth)	complications that rause only one cause on each	Due to (or as	12(no not ente	Ol NORTH r the mode of dy Approximately and the mode of):	MARK ing, such es	ET ST	SON FUNE FRED raspiratory erre	ERTCK.			tween	
leath certificate be executed attending physician and for use as the burial-transit	Medical	Med	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c	Due to (or as									
v requires that the death cer been signed by the attendir should be detached for use	Completed by Physician/	Part It. Other algnificant condition	I.	23b. Did tobacco use contribute			the causa bably 4							
v requires been sign should be	leted by	. 01							24a. Wes en		col	ere eutopsy sileble prior mpletion of death?	to	
The law require ate hes been si page 2 should I	E								4 TO V-	· Min		1	1 110	
certificate	ö	DE Was once referent to the "						10	1 Ye		1	Yes 2] No	
certif	Be c	25. Was case referred to medical axaminer?	Hospitel:	V			ther:		(Check only one					
Physician: this certific ral director.	- To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj		Outpatient Time of	3LI DOM	4 L N		ne 5 Reside			y)		
or Attending Physician: Tafter death. Director: After this certificat d in by the funeral director. p	ation	Neturel 5 Pendin investig	g (Month, Di		Injury	28c. tnje We M 1	ork? Yas 2		ou. Describe no	w injury occur				
after Att	Director: Affect led in by the tuners Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	2	28f. Location (Street end Number or Rurel Route Number, City or Town, State)										
To the Hospital or Atlanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	edicai C		g Physician: To the best Examiner: On the basis of and menner's	of examination									(s)	
To the Ho within 24 To the Fu	X	29b. Signatura and the of partition 29d. Data signed (Month, Day, Year)												
L > L 0		* Till	L. Kark	m		カー	1.20	777		1/2	10	0		
	-	30 Name and address of nessen	uto completed bales of	death (Itam 22	a) (Type E	(rint)	101	11		11	100			
		30. Nama and address of person who completed base of death (Item 23a) (Type, Print)												
Sta	•	31. Data filed (Month, Day Year)	32. Regist	ra/s Signature	411	UI								
518	LE L		M 4 004	1.										

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Wilson Mildred Grace 6, 2000 January 1:46 pm 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Allegany Cumberland If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Day Ye Oct 10, 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1917 Birthplace (State or Foreign Country) MD 10 M 20 Days Months Hours 216-22-5720 82 Usual Residence of Decedent 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yea 2 ☐ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13825 Pinto Road, SW USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ ‰ If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1□Yes 2□No Specify. Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Ammunition Factory Worker 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Mike Cosgrove Bertha (Deetz) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13825 Pinto Road, SW: Cumberland MD 21502 19a. Informent's Neme/Relationship (Type, Print) Patricia Collins 20a. Meliosof Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 1 □Xuriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/10/ Cumberland, MD Sunset Memorial Park 21. Signature of Fusieral Service Licenses 22 Scarperid For uneral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or complete upons thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feilure. Litat only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting In deeth) 10 years Chronic obstructive lung disease Due to (or as a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated eventa resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably ◀ Unknown Diabetes mellitis 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 28 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Magner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Records, P.O. Box 68760 of Vital or Attending Physician: **Physician**

Examiner

Funeral

Director

28a-f show

ŏ

23a

8

"nattural"

Hygiena.

nt of Health a if them 27 is or other trai

Department of Important: If any injury or

Physician

Examiner

and

physician

/Medical

the buriel-transi

90 use

signed by the a

peed

hes page 2

certificate

this

After

death.

4 hours after death funeral Director: /

within 24 hours a

9

funeral director,

filled in by

completely

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

4 Homicide

(Check only one)

29b. Signature and title of 9

29e. Certifier

Director

Funeral

þ

Completed

Be

the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.

Baltimore, Maryland 21215-0020

/Medical

216-22-5720 Hospital

Mildred Wilson Division

> 8 State Registrar

Dr. Vik Poonai 31. Date filed (Month, Dey, Year) JAN 1 1 2000

920 National Highway 32 Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LaVale, MD

Certifying Physician: To the sest of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner steted.

D36766

29c. License number

29d. Dete aigned (Month, Day, Year)

January 10, 2000

IANII 2000 promote to former

State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Deta of Death Month **Physician** John Gilpin Ward 0645 2 2000 Januar /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford W Under 1 Year | W Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 1908 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Maryland 215-12-3075 91 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location t0d. Inside City Limits 1 Yas 2 No Maryland Harford 280-7 Directo Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Nems 23a Funeral 21050 2315 Rock Spring Rd USA 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 XNo Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7 Hygiene. other than 'n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied with Department of Health and Mental Hygien important: If Item 27 is marked other the any Injury or other traumado event. Road Maintence Public Works 6 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Be Goven Ralph Ward Hannah Jane Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Ward / Wife 2315 Rock Spring Rd., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Deer Creek Methodist Cem. 1-5-00 Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014

To or complications that caused the death. Do not enter the mode of dying, such as Cardiac or respiratory arrest,

List only one cause on each line. Enter the disease Approximata Intarval Batwe Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) STENOSIS ORTIC Examiner Examine physician and the burlat-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 987 Part II. Other significant conditions contributing to death but not resulting in the underlying chuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Congestive 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Wara sutopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed hes 1 Yas 2000 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 10 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Attending i or Attending after death. Director: After 1∏ Yes 2∏No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

P Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY. S. NAIR M.D. 2112 Belain Road. Fallston. M.D. 21047 31. Data filed (Month, Day, Year) JAN 0 5 2000

Registrar **DHMH 16 Rev 6/95**

State

32. Regis ar's Signature

DAY & WAL

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 724 aco 00 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Washington County Hospital Washington Hagerstown If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year) JUNE22, 1925 5. Sociel Security Number 6. Sex 9. Birthplaca (State or Foreign 1 2 F Days Months Hours Maryland 219-20-0904 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limite Washington 1 Yes 2 No Md. Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13605 Ritchie Rd. 21719 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grit Mill Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Virgie M. Cline Norman E. Wade 19a. Intermant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene J. Wade (Sister) 13605 Ritchie Rd. Cascade, Md. 21719 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Tan. 1 Buriai 2 ☐ Cremation 3 ☐ Removel from State Bethel Cemetery 5 Other (Specify) Cascade. Md. 7.2000 Signature of Funeral Service Licary 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as e cor Due to (or as a consequence ot) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to 24a. Was en autopsy periormed? completion of cause of death? 2 PINO

Physician /Medical Examiner

burial-transit

tha

980

signed by t

Completed

Be

Certification: To

Medical

and

physician

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

10a State

6

Funeral

Director

28a-f show

"natural", or items 23s or

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If Item 27 is marked other?

must be

Director

Funeral

À

Completed

Be

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical p

1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 10 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

Could not be

29c. License number

29d. Date signed (Month, Day, Year)

State

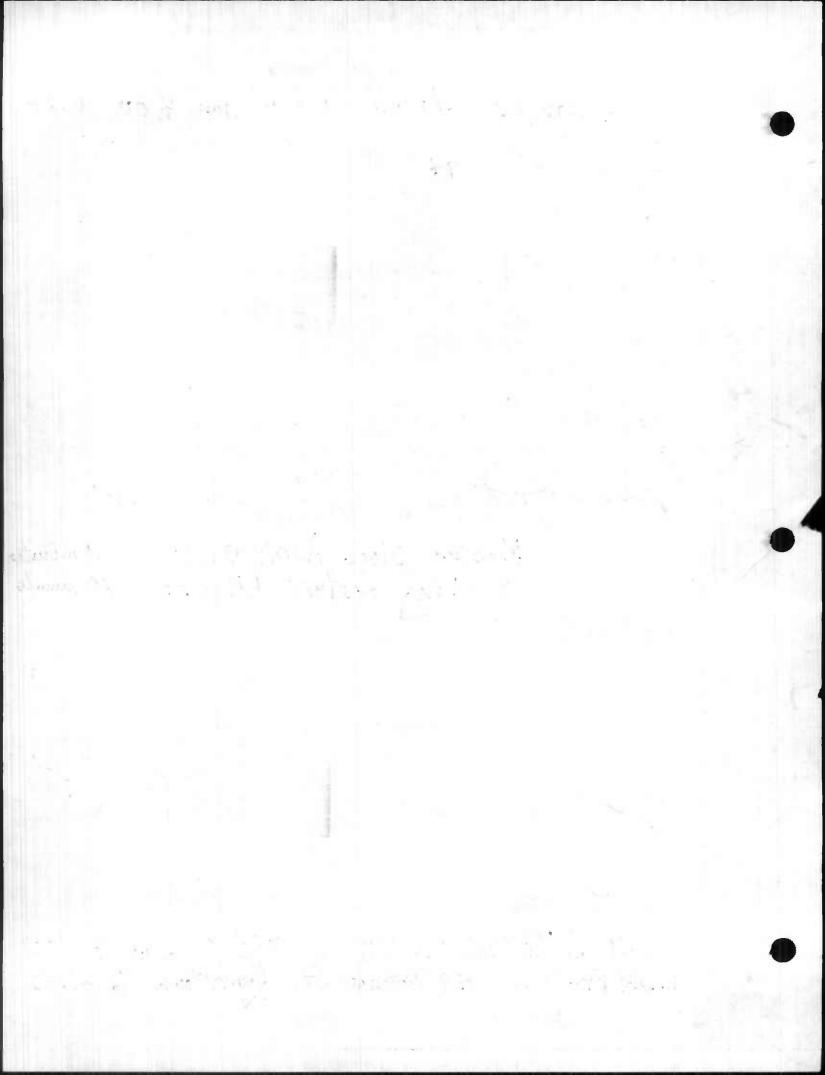
JAN 0 5 2000

32. Registrar's Signature

Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year Michael Yonko. Sr. 2000 06 2000 /Medical January 4b. City, Town, or Location of Death 4a. Facility Nama (If not Institution, give street and number) 4c. County of Deeth **Examiner** Union Hospital Elkton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 22, 1903 Ukraine 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** 120 M 2□ F Months Days Yrs Director 96 213-10-9763 Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, in Macical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maruland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive Funeral 21921 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Haneny injury or other traument. Black, White, etc. 1 ☐ Never Marriad 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕱 No Specify: py 3 ₩ Widowed 4 Divorcad Specify White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Assembly Worker Auto Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Danniel Yonko Pauline Smutnika 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Guiberson/Daughter PO Box 183 Chesapeake City, MD 21915 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBuriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Rose of Lima Cemetery 1-10-00 Chesapeake City, MD 21. Signature of Funeral Service License 22. Neme end Address of Facility R. T. Foard Funeral Home, P. A. 318 George St., Chesapeake City, MD 21915 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Que to (or es a consequenca of) Examiner buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In daath) Last Due to (or es e consequença of): P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of): ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings evallable prior to completion of causa of death? 24e. Was en eutopsy performed? Completed peen page 2 cartificata 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, and due to the ceuse(s) and manner as stated. Provides: 10 the best of my knowledge, death occurred at the limb, determine the limb, determine to the basis of examination and/or investigation, in my opinion, death occurred at the time, determine due to the cause(s) and mannar stated. 29b. Signeture and title of certifiar 29c. Licanse number 29d. Dete signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 6

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 1 2000

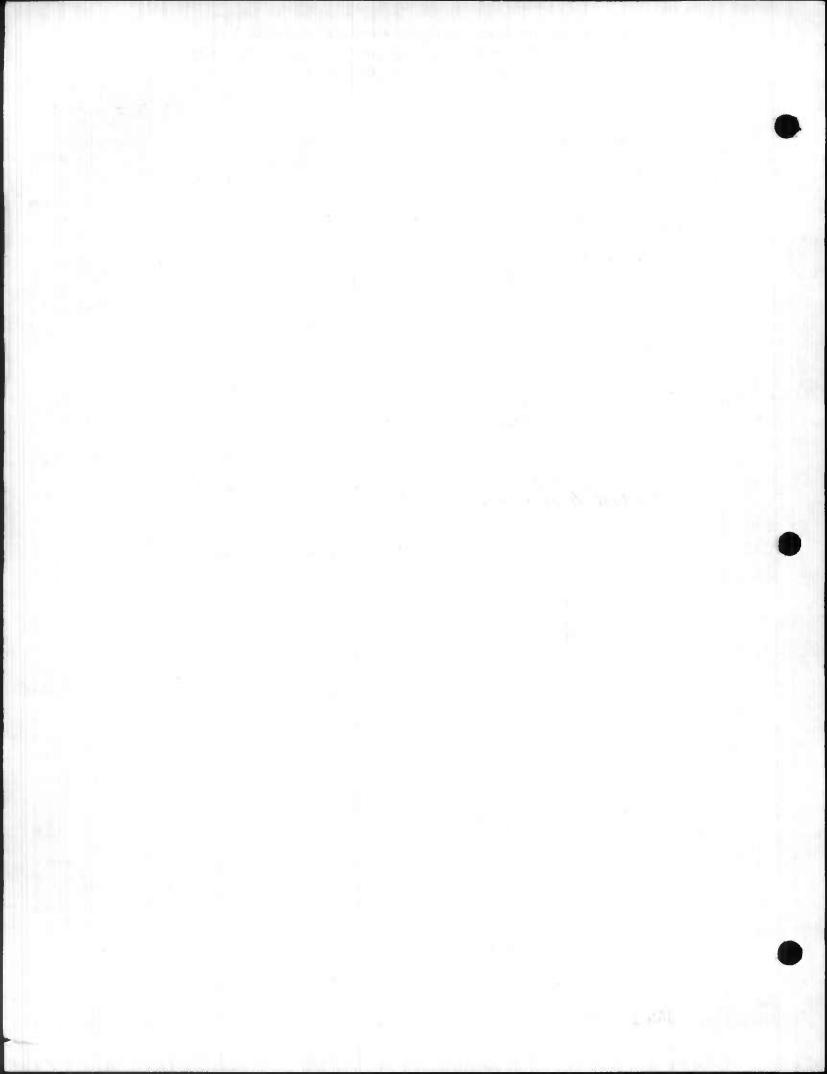
Goodill

Separate Separate

32. Registrar's Signeture

G. Aparls

111 W. High St., Suite 103 Elkton, MD 21921



State of Maryland / Department of Health and Mental Hygiene

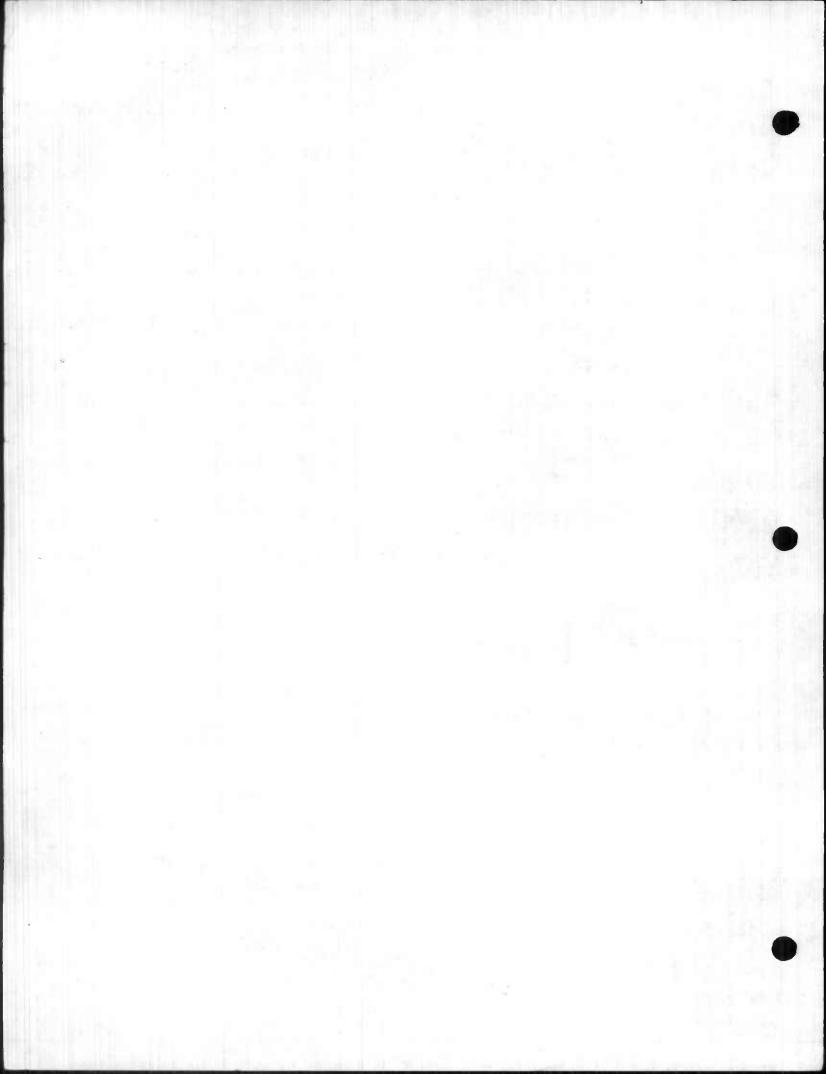
				ate of Death		eg. No.	01265						
Physician /Medical	FRANLI	BERNARD	YATES		2. Date of Dea Month	January January January	3. Time of Death 12:55 At						
Examiner	4a Facility Name (If not institution, give				or Location of Death	4g. County of Deet							
Funeral Director	Southern Maryland 5. Social Security Number 579-26-9124 6. Security Number			Clinton der 1 Year H Under 24 H hs Deys Hours M		Prince George's 8. Dete of Birth (Month, Dey, Year) Sept. 24,1924 Washington, D.							
D 3	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits						
Maryi			Oxon I	4:11		-0.00	1 Yes 2 No						
vith the Me tor 28a-f a be notified	10e. Street and Number	corge 5	1	Zip Code	1	0g. Citizen of What Co	untry?						
th with				20745	476.00	U.S.A.							
d 21215-0020 filed within 72 hours after death with the Maryland Hyglens. ther than "natural", or flems 23a or 28a-f show ont, the Medical Examinar must be notified at a Completed by Funancial Director		12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu 2 X No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.						
1 21215-0020 de within 72 hours at yor than "natural", or tt, the Medical Exem Compilated by F		ucation de completed) College (1-4or 5+)		isual Occupation work done during most of a Tuse retired) alesman	working	16b. Kind of Business/	Industry						
and 212 be filed within thal Hygiene. d other then event, the M	17. Father's Name (First, Middle, Last)		Parts 3		Neme (First, Middle, I		2						
E 255 0		.s		Bland	che Teresa	Sollars							
faryla 2 should and Men 1e marks surrante	19a. Informant's Name/Relationship (7	ype, Print)	19b. Meiling Addr	ess (Street end Number or	Rural Route Number	City or Town, State, 2	(ip Code)						
CENL	Kathy E Kimble/D		_	ndsor Drive,	1								
0 :0 = 2	20a. Method of Disposition 1 ☐ Burial 2 🌣 Cometion 3 ☐	Removal from State	Place of Disposition (i cemetery, cremetory of	or other place)		20c. Location - City or							
Baltime pemir. Pag Department important: if any injury o	4 □ Donation 5 □ Other (Specify 21, Signatured Europe Service Dicer-	2	untt Crema	end Address of Facility	1-13-2000	Waldorf, M	laryland						
Balt pemit. Depart Import eny inje	1 act of	Stont	The	Huntt Fuenr	al Home,	Inc.	504						
mew	NARK G. BROHAWN M00053 P.O. Box 156, Waldorf, Maryland 20604 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Betw. Onset and D.												
Medical Examiner of the Principle of the	Immediate Cause (Final disease or condition resulting in death) A RESPIRATORY FAILURE Due to (or as a consequence of): PLEURAL EFFUSION Due to (or as a consequence of): METASTATIC ADENOCARCINOMA												
BOX 687 ath certificate titlending physic use as the	that initiated events resulting in death) Last	Due to (c	or es a consequence d	of):		obacco use contribute	to the cause of death?						
bed by the detached		L CELL		0.44 ()	1 🗆 Y	es 2.0No 3. Pi	robably 4 Unknown						
Aecords lew requires has been sign to 2 should be		CLEROTIC (CARDIOVA	SCULAR DISC		med?	Were autopsy findings available prior to completion of cause of death?						
Vital F icien: The centificate rector, pag	25. Was case referred to medical			26 Place of I	Death (Check only on		1 ☐ Yes 2 ☑ No						
Of VIta Physician: this certific ral director,	axaminer?	Hospital:	ER/Outpatient 3	Other		ence 6 Other (Spe	cify)						
ding Physical Street St	27. Manner of Death 1 Manual 5 Pending	26a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe he	ow Injury occurred							
or Attentifica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)	1 ☐ Yes 2 ☑ No tory, office	City or Town	Altion (Street end Number or Rural Route Number or Town, Stete)							
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by Medical Certiff	(Check only 2 Medical Exam	reician: To the best of my kno iner: On the basis of examine	owledge, death occurration and/or investiget	ed at the time, date end plo ion, in my opinion, deeth o	ece, and dua to the courred et the time, d	ause(s) end manner as	stated. to the cause(s)						
o the lithin 2 of the pomplet	29b. Signature and title of certifier	and manner stelled.		29c. License number		9d. Dete signed (Monti							
F * F 8	3 mil 1	Henry "	7.0	020986		1-7-00							
	30. Name and address of person who c			RO CLIN	TON MD	20735							
State	31. Date filed (Month, Pay, Year)	32. Registrar's Signe	etura 4	las v.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ner 14 2000 homas 07:13 EMANUE privare /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death Examiner 13A/timore Iniversit IARY/Amy JUSTEMS 10121 **Baltimore City** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 MM 2□ F Montha Hours Yrs. Director 397-28-1196 February 8, 1933 Wisconsin Usual Residence of Deced 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23a 21046 U.S.A. Funeral 7040 Gentle Shade, Apt. 101 12. Wea Decedent Ever in U,S. Armed Forcea?

1 12 Yea 2 10 No HYds, Give 14 Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bleck, White, etc. Poarmit. Pages 1 and 2 ahouid be filled within 72 hours after of Department of Health and Mental Higgiste. "Important: if them 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examinos odde. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yea 2 No Specify: 1953 by 3 ☐ Widowed 4 ☐ Divorced White 1955 Completed 16b. Kind of Buainess/Induatry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Logistics Manager 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Willard Eugene Archer Esther Emanuel 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Carolyn Archer Wife 7040 Gentle Shade, Apt. 101 Columbia, Maryland 21046 20b. Ptece of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Crametion 3 ☐Removel from State Somerset County Memorial Park, 101/18/2000 4 ☐ Donation 5 ☐ Other (Specify) Somerset, Pennyslvania 22. Name and Address of Facility 21. Signature of Funeral Service Lioensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Tho 1101204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ettending physicien and for use as the buriel-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 | Yes 2 | No 3 | Probably 4 Nonknown by Records, The lew requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? pege 2 i 2 No 1 Yea Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No r deeth. n 24 hours effer deeth. He Funeral Director: A pletely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) To the To the To the I 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Street 2 0 2000 32. Registrar's Signatur State Registrar

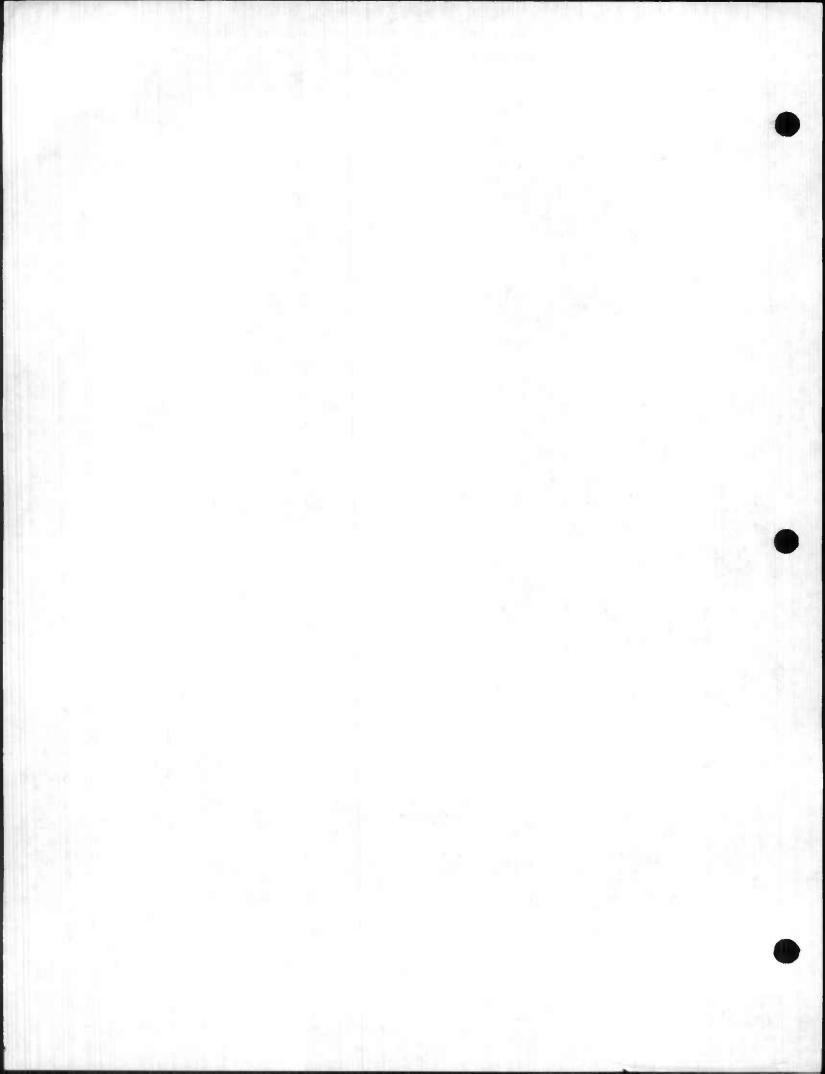
DHMH 16 Rev 6/95



			1		_
State of Maryland / Department of Health and M Certificate of Death	Reg. No.	UU	UI	20	
State of Maryland / Department of Health and M	lental Hygiene	00	01	20	

Priscilla J. Bloom Supering	h Reg. No. UU UIZI	Death	ate of	Certif								
Security Number 1							irst, Middle, La	1. Decedent's Neme				
Second Security Number Second Security Num	4.0			oom	a J. E	Prisci						
S. Social Security Number C. See 219-05-8057 C. See 219-05	Fown, or Location of Deeth 4c. County of Death	4b. City, Town, or L	4	6		treet end number)	t institution, giv	4a Facility Neme (If				
Upus Residence of Decedent Upus Residence	Randallstown Baltimore	Rai			al Cente	hwest Hospi	No					
219-05-8057 10s. State 10b. County 10c. City, Town or Location 10d. Sykesville 10d. Specify 10d. Spe	er 24 Hrs. 8. Dete of Birth 9. Birthplece (State			M				5. Social Security Nu				
10a. State 10b. County 10c. City, Town or Location 10d. Maryland Carroll 10d. Carroll 10d. Extremely 10d. Sykesville 10d	July 9, 1920 Maryla			Yrs.	7	M ZICLF	57	219-05-				
Maryland Carroll Sykesville 106. Zip Code 109. Citizen of Whet Country 100. Zip Code 100. Zip Code 109. Citizen of Whet Country 100. Zip Code 100. Zip Cod	10d. Inside (un or Locati	10c City							
Maryland Carroll Sykesville 100. Zip Code 21784 109. Cilizen of Whet Country 100. Johnsville Road 101. Zip Code 21784 102. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No.) 11. Merital Status 10. North Marind 20. Ma	1 × Yes			WIT OF LOCAL	Tou. Oity,		o. County	TOB. State				
10.08 Johnsville Road 11. Mental Status 12. Mas Decedent Exercine 13. Mes Decedent Cripin' (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Mas Decedent Statusian 12. Mas Decedent Statusian 12. Mas Decedent Statusian 12. Mas Decedent Statusian 13. Mes Decedent Statusian 14. Race - American 15. Decedent's Statusian, Mexican, Puerto Rican, etc.) 16. Decedent's Unual Occupation (Give kind of work one working Iffe. Decedent's Unual Occupation (Give kind of work one working Iffe. Decedent's Unual Occupation (Give kind of work one working Iffe. Decedent's Unual Occupation (Give kind of work one working Iffe. Decedent's Unual Occupation (Give kind of work one working Iffe. Decedent's Unual Occupation	sville	Sykesville			`	arroll						
11. Merital Status 11. Merital Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-li'yes, specify Cubin, Mexican, Poerfor Rican, etc.) 14. Race - American Brack, White, etc. 15. Decedent's Education (Specify only highest grede completed) 12. Was Decedent's Usual Occupation (Specify only highest grede completed) 12. Was Decedent's Usual Occupation (Specify only highest grede completed) 12. Was Decedent's Usual Occupation (Specify only highest grede completed) 12. Was Decedent's Usual Occupation (Specify only highest grede completed) 13. Meritan of development of the Universal of the		24704	Zip Gode									
1.1 Yes. 20 No. Specify: Specify							sville Road					
Specify Spec	an, Puerto Rican, etc.)	oan, Mexican, Puerto	specify Cuba	13. Wes		Armed Forces?	A					
15. Decedent's Education 16. Kind of Business/house 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 18. Mother's Name (First, Middle, Meiden Sumeme	fy: Specify: White	Specify:	s 2 No	10	0	If Yes, Give	, ,					
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meders Sumente)	16h Kind of Rusiness/Industry	nation	Isual Occup	Decedent								
17. Father's Name (First, Middle, Medien Summer) 18. Mother's Name (First, Middle, Medien Summer) 19. Mother's Name (First, Middle, Name (First, Name Number) 19. Mother's Name (First, Name (First, Name Number) 19. Mother's Name (First, Name (First, Name (First, Name Number) 19. Mother's Name (First,	ost of working Home	during most of work	work done	(Give king		completed)	only highest gre	(Specif				
17. Father's Name (First, Middle, Medien Summer) 18. Mother's Name (First, Middle, Medien Summer) 19. Mother's Name (First, Middle, Name (First, Name Number) 19. Mother's Name (First, Name (First, Name Number) 19. Mother's Name (First, Name (First, Name (First, Name Number) 19. Mother's Name (First,		Homemaker	Н		+)	College (1-4or :		Elementery/Secon				
19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Co. James O. Bloom 1008 Johnsville Road Sykesville, Maryland 21784 20c. Method of Disposition 12 Due to (Disposition (Neme of carefully) or Other placa) 20c. Place of Disposition (Neme of carefully) 21. Signature of Funeral Service Licensee 22. Name and Address of Feelity 21. Signature of Funeral Service Licensee 22. Name and Address of Feelity 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or shock, or hear failure. List only one cause or each line. 25 Due to (or as a consequence of): 25 Superventricular tachycardia 25 Due to (or as a consequence of): 25 Due to (or as a consequence of): 26 Due to (or as a consequence of): 27 Due to (or as a consequence of): 27 Due to (or as a consequence of): 28 Due to (or as a consequence of): 28 Due to (or as a consequence of): 28 Due to (or as a consequence of): 29 Due to (or as a consequence of):	her's Name (First, Middle, Meiden Surneme)	18. Mother's Nam					st, Middle, Last)	17. Father's Name (F				
19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Co 1008 Johnsville Road Sykesville, Maryland 21784	Ida Coleman					am Frey	Wil					
20a. Method of Disposition Buriel 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Lorendory) or other places) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and other cause of each fine. 25. Name and Address of Facility 25. Name and Addre	ber or Rural Route Number, City or Town, State, Zip Code)	t end Number or Ru	ress (Street				19a. Informant's Ner					
20a. Method of Disposition Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee Licensee	oad Sykesville, Maryland 21784	ville Road Syl	8 Johnsy	10	and	Husl	O Bloom	.lam				
St. John's Cemetery O1/10/2000 Ellicott City,	Date 20c. Location - City or Town, Stete	20a. Method of Disposition 20b. Place of Disposition (Name of compatent or other place) 20c. Location - City of compatent or other place)										
21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043	01/10/2000 Ellicott City, Mary	St John's Cometeny										
Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043		ess of Fecility	and Addre	22. N		0						
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Begunnitally list conditions, if any, leading to immediate caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, in the line disease or condition resulting in deeth) Begunnitally list conditions, if any, leading to immediate caused the death of the line of the li	ral Home, P.A.	k Funeral Hor	Slack	4	MOIZ	111	6	1 7/1/				
Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to death but not resulting in the underlying cause given in Pert I. A nemia Gastrointestinal bleed 24e. Was en eutopsy performed? Castwas case referred to medical axaminer? 1 yes 2 No 1 yer of the property of the				1								
Cause (Disease or Injury their initialed events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Superventricular tachycardia Due to (or as a consequenca of): Due to (or as a consequenca of):											
Gastrointestinal bleed 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2												
Gastrointestinal bleed 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2	d I 23h Did tobacco use contribute to the cause	Part II. Other significant conditions contributing to death but not resulting in the undertune cause gives in Part I										
Gastrointestinal bleed 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2	1 Yes 2 No 3 Probably 40											
Gastrointestinal bleed 24e. Was an eutopsy performed? 1 Yes 2 No 2 Yes 2												
25. Was case referred to medical axaminer? 1 Yes 2 No												
25. Was case referred to medical axaminer? 1 Yes 2 MNo 1 Inpatient 2 ER/Outpetient 3 DOA 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)	1 Yes 2 No 1 Yes 2											
1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)		26. Plece of Dea					to medical					
		thor:	DOA Oth	utpetient	1 2 KE	ospitel:						
1 Netural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how injury occurred □ No		28c. Injur Wor	Time of	/ 2	28e. Date of Inju						
27. Menner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28e. Date of Injury 28e. Date o	28f. Location (Street end Number or Rural Route Nu City or Town, Stele)		3 Suicide 6 Could not be determined									
29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as state 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the and menner stated.					examinetio	er: On the basis o		(Check only				
29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, De												
Juca John Mildun DO052760 January 7.	00052760 January 7, 200	D00527		du	Mi	Phi	100	1				
30. Name and address of person who completed cause of deet/f (Item 23a) (Type, Print)	BUILDING I AND											
Erica Tobin-Muldrow, MD 5401 Old Court Road Randallstown, MD 21133												

DHMH 16 Rev 6/95



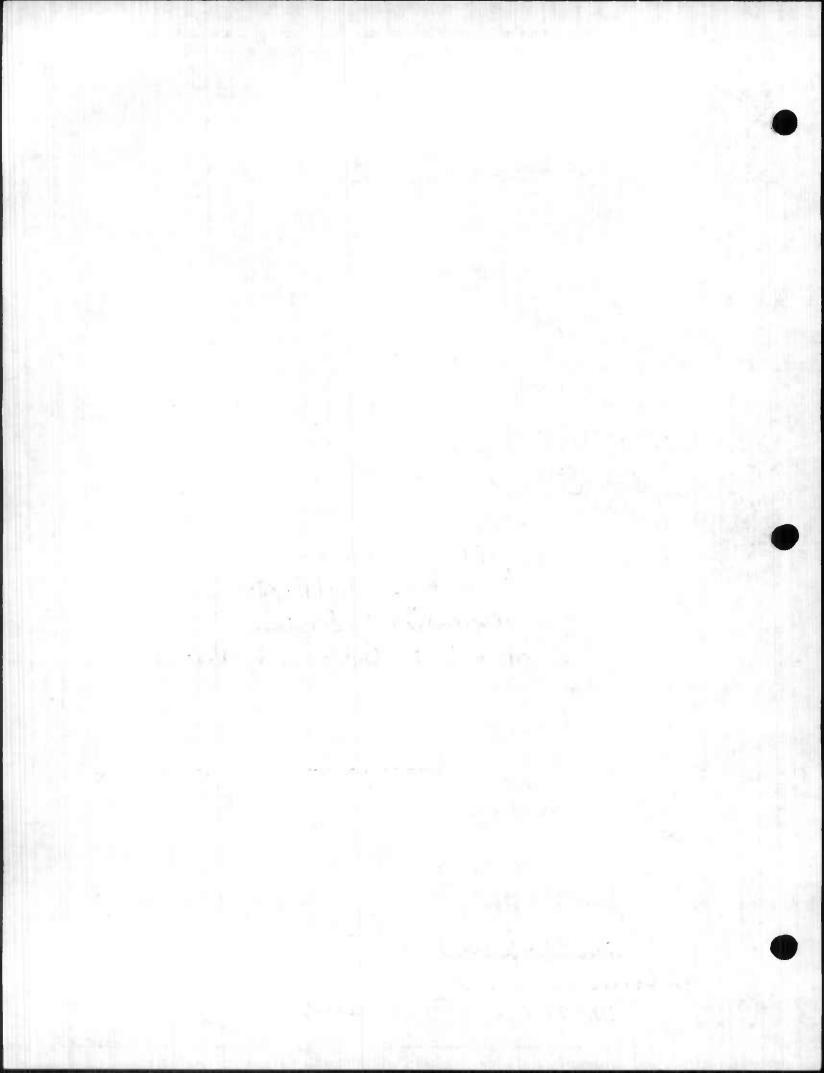
00-0270-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	ARK RADT		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.									1268		
		1. Decedent's Neme (First, Middle	e, Last)							2. Dete of Dee	eth	Year	3. Time of Death	
	Physician /Medical	MARK BRADT								JANUARY			6:55P.M.	
)	Examiner	4a Facility Name (If not institution ST.AGNES HOSPIC		ber)			4		wn, or Local TIMO	cation of Death RE	4c. Count	y of Deeth		
	• Funeral	5. Social Security Number	6. Sex 7.	. Age (In yrs. last		If Under Months	1 Yeer Deys	If Under Hours	Min.	8. Date of Birth Month, Day, Year) July 27, 1966 Ma			placa (Steta or Foraign Tand	
	Director	220.94.3752 Usuat Residence of Decedent	XXW 221	33	Yrs.				4	uly 2/	, 1966	Mary	land	
	B # 10	10a. Stete 10b. County		10c. City, To	own or Lo	cation						1	IOd. Inside City Limits	
	Mary Fled	MD Balt	imore	Balt	imor	e Hig	hlan	ds					1 ☐ Yes ANO	
	with the Maryla a or 28a-f show De notified at Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cour	ntry?	
	n ell and la control and the c	3034 New York	Avenue			21	227				USA			
20	urs after death vir., or flams 23s complex must	11. Meritel Stetus 1 Never Merried 2 Merr 3 Widowed *XXDivorced	12. Wes Deced Armed Force 1/ Yes 2 If Yes Give	□ No	1	Wes Deced if Yes, spec 1 Yes 2		ispanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	14. Ra Ble Specia	ck, White,	can Indian, etc.	
8		15. Deceden		Yeer or Detes: on 16a. Decedent's Usuel Occupation							16b. Kind of B	Business/In	dustry	
215-0020	ed within 72 ho ygiene. wer then "naturn it, the Medical. Completed	(Specify only highes	st grade completed)	rk dona d se retired	a during most of working					,				
21	The stand	Elementery/Secondery (0-12)									Harbor	Mgmt	. Inc.	
and	2146 8	17. Falher's Neme (First, Middle,									me)			
	Wenta Wenta affice To E	Richard Willi	William Bradt Emily George											
fary	and and	19e. Informent's Neme/Ralations		er, City or Town										
6,	and 2 s oalth an m 27 is r her traus	Richard W. Brad	t - Father					ls Fe	rry R		nthicum			
timore,	or man	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion	3 □Removel from St	come	etery, crei	netory or of	her plea	e)		Data	20c. Location			
E	Sician and	4 ☐Donetion 5 ☐ Other (S	pecify)			ran C					Crowns			
Bal		21. Signature of Funeral Service	Ly Fink			26 Cr					eral Ho Burnie,			
		23a. Part 1. Enter in discussion or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failured ist only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or is a consequence of):												
x 68760,		Sequentietly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disaese or injury that initieted events rasulting in death) Last	b. Neufe Mys cordial Pupture Dua to (or as a obsequence of): Due to (or es e consequence of): d. Arteròscherotiz Cordis Coscular Disease								2			
Вох	atten for u	Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to											and the second of the set of	
P.O.	requires that the death certifica een signed by the attending ph hould be detached for use as the cited by Physician/Med	Pert II. Other significant condition	ns contributing to deal	l.		bably 4 Unknow								
Records,	100									24a. Wes	en autopsy mad?	al.	/ara eutopsy findings valiable prior to completion of cause death?	
E E	The law ste has page 2										res 2 No	V	Yes 2□ No	
Vitai	ysicien: The last confidence has director, page	25. Wes case referred to medical						26. Place	a of Death	(Check only o	ne)	1		
>	Physician: this certific ral director, ral director,	exeminer? 1 Yes 2 No	Hospitel: 1 Inf	patient 2X ER/	Outpatier	nt 3 DO	A Oth	ar: 4 N	ursing Hor	me 5 Resid	dence 6 🗆 Ot	her (Speci	(y)	
Division of	ath.	27. Menner of Death Natural 5 Pandin 2 Accident investig		tnjury 280 Dey Year)	b. Time o Injury	M 2	8c. Injur Wor	yat k? Yes 2 □		28d. Describe I	now injury occu	rred		
Divis	is or Attending P is after death. The Director: After t led in by the funera Certification:	3 ☐ Sulcide 6 ☐ Could determ	ned 288. PIECE 0	t be 280 Place of taking At home form street feature office						281, Location (S City or Tox		ber or Rur	al Route Number,	
	To the Hospital or Attending Physical to the Funeral Director: After this completely filled in by the funeral director. After this completely filled in by the funeral director. To Medical Certification: To	29a. Certifier 1 Certifyin (Check on) XX Medical	g Physician: To the be Examiner: On the bas and menne	is of examinetion	dge, death end/or in	occurred a	at the tin	na, data ar pinion, des	nd placa, a eth occurre	and dua to tha ed at tha time,	causa(s) and m date end ptece	nannar as a , snd due t	stated. to the cause(s)	
	To the comp	29b. Signety and title of certifie	Cole	and		290		e number		10	29d. Dete sign			
	25+1	30 Name and address of person who complated cause of daeth (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201												
	State Registrar	31. Dete filed (Month, Day, Year) JAN 2		gistrar's Signeture		9 1	pa	KV						

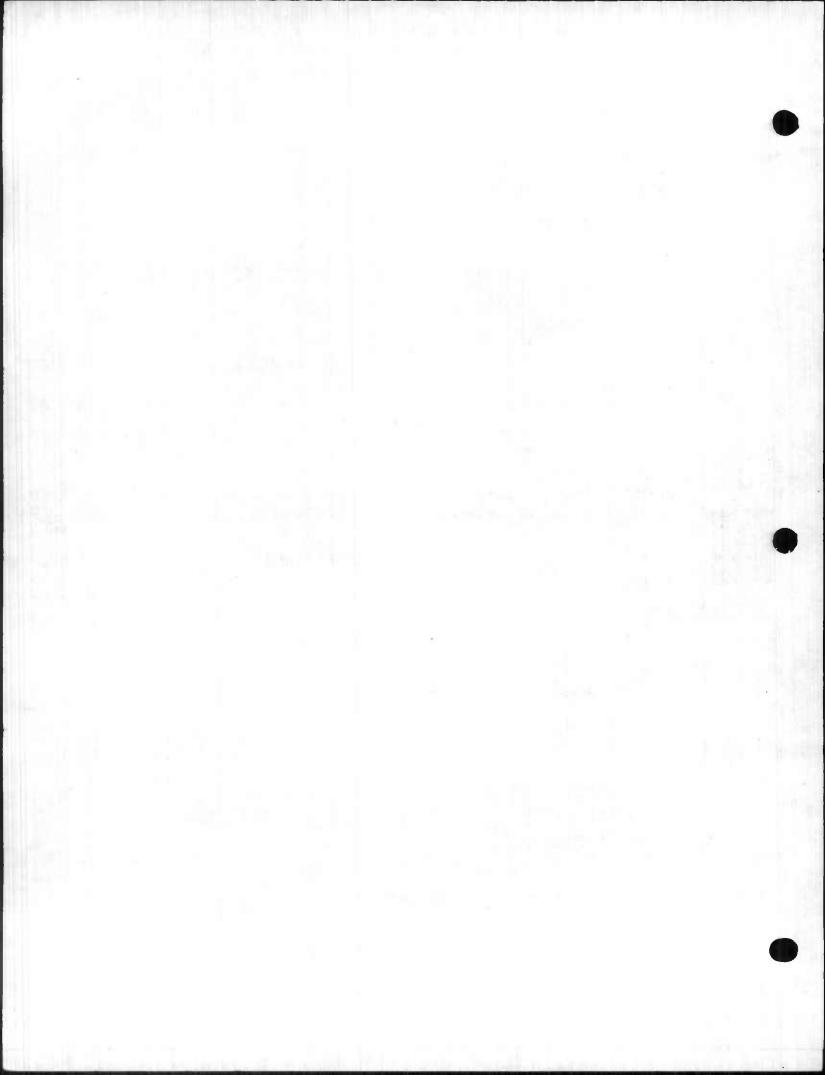
DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 01269

Physician Medical Examiner Dispertment of Health and Mental Hygiens End of the mental Hygiens Important: If Item 27 is marked other than "netural; or item 23s or 28=1 show Interpretation of other traumatic avent, the mental of the men				Certifica	ate of	Death		R	eg. No.		1 6 0	
Physician	1. Decedent's Name (First, Midd							2. Date of Deat Month JANUARY	h Day	Year	3. Tima ot	
Physician //Medical Examiner 4a Facil 194- Examiner 5. Social 194- Usual Relative process of the strength of	KOBI	ert bik	LNZY					16 4	2000	7:15	1.1	
Examiner	4a Facility Name (If not institution		r)					cation of Death	4c. County	of Death		
	HARBER	HOSPITAL					LTIM					
	5. Social Security Number	6. Sex 7. / 120 M 2□ F	Nge (In yrs. last b. 68	Yrs. H Und	ler 1 Year s Days	If Under	24 Hrs. Min,	8. Date of Birth (Month, Day, 8/22/19	Year)	Birthplaca (State or Fo Country)		
director	194-20-9259 Usuat Residence of Decedent	AA		113.				8/22/19	31	Mary	Land	
£ ==	10a. State 10b. Count	/	10c. City, Tov	wn or Location						11	0d. tnside Ci	ity Lir
de lo	Md Roll	timore City	Rolt:	imore Ci	+37						1 🗆 Yes	M
190	10e. Street and Number	cimore city	Darc.		Zip Code			1	Dg. Citizen of \	What Coun	try?	
Se di	518 Holy Cros	s Road			2122	5		USA				
78.2	11. Maritat Status	12. Was Deceder	t Ever in U,S.	13. Was Dec	edent of h	lispanic On	gin? (Spe	cify Yes or No- Rican, etc.)	e - Americ			
X 0 -		Armed Forces			2 No		, Puerto	Hican, etc.)		ck, White,		
5 6		1 Yes, Give Year or Dates	:	1 LJ Yes	2414NO	Specify:		Specify: Whit			LE	
of Bet	15. Decede	nt's Education est grade completed)	164	Decedent's Us	sual Occup	ation	t of worki	16b. Kind of Business/Industry			dustry	
	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. DO NOT	use retire	d)					ity Do	11
Set O	12]	Patrolma	n-De			Baltimore Ci			ILY IC	, 1
2 2 2	17. Father's Name (First, Middle						ne (First, Middle, Maiden Surname)					
5 5 C	Charles Birne							th Birne	,			
	19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19c. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19c. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19c. Informant's Neme/Relationship (Type, Print)											
m 27												
208	20a. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci											
	4 Donation 5 Other (Specify) MD Veteran Cemetery 1/20/2000 Crownsvill 21. Signaffice of Funerel Service Liberture 22. Name and Address of Facility FINK FUNERAL HOME, I											
DE PO	21. Signature of Funerel Service	Ligangee								-		
= 3		ry Fink		426 0	Crain	Hwy.	, SW	Glen Bu	rnie,	MD 21	061	
	23a. Part 1. Enter the disease, of shock, or heart feilure. Lis	r complications that cause t only one cause on each	ed the death. Do line.	not enter the m	ode of dyir	ng, such as	cardiac o	or respiratory erre	est,	-	Approximate Interval Beh	B
			Onset and I)eet								
_	thmediate Cause (Finel disease or condition a. Concestive HEART FAILURE										10 40	al
	Due to (or as a consequence of):										10 ge	
a sin	SENELE COTOMORY BLIEBY MISSASE											W
And Hran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
burle E												
phys the	that initiated events resulting in death) Last Due to (or as e consequenca of):									i		
00		d										
for u												
ched ched	Part II. Other significant conditi									obacco use contribute to the cause of		
P deta		c RENDL	FAIWLE					1 V	aa 2 No	3 Prot	oably 4	Unk
d b		Ode Was an extensi									ere autopsy t	lindir
should be seen	2. PAROXY	emac ATRI	are fi	BRICHT	IGN			perform	ned?	CO	ailable prior to mpletion of co death?	aus
oge 2	3. CHLONE	OBE TRUCTI			- 140			400	a PA			
S. P. S.	25. Was case referred to medical		VE MIL	way 018	ZASE	00 01	1.69		s 2 No	11	Yes 21	No
irect and O	examiner?	Hospital: 1 🗹 Inpa	tient 2 ER/O	utpatient 3 1	Oth	AP.		n (Check only on me 5 ☐ Reside		on Const	41	_
oral o	27. Manner of Death	28a. Date of In		Time of	28c. Injur	4 🗀 140		28d. Describe ho			7)	
fun fun	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, E igation	lay Year)	Injury M		rk? Yes 2 🔲 I	No					
fice fice	3 Suicide 6 Could	not be 28e. Place of I	njury - At home, f	arm, street, fect	ory, office		1	28f. Location (St		ber or Rura	I Route Num	ber,
din din	4 Homicide	building, e	Se. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)						, State)			
al C	29a. Certifier 12 Certifyi	ng Physician: To the bes	t of my knowledg	e, death occurre	d at the tir	ne, date an	d place, a	and due to the ca	use(s) and m	enner as st	lated.	-
die Fu	2 9a. Certifier (Check only one) 2 9a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.)
Me We	29b. Signature and title of certific	or		2	9c. Licens	e number		2	9d. Date signe	ed (Month, Day, Year)		
- 0	1 Paulan	m.D.	, 1		P 1:	3472		7	ANVALV	16, 2000		
	30. Neme and address of person			(Type Driet)						-0	, ~ 0	50.
1+1		0.4.174			a u	0007	М	and, Time	-08			
State	31. Date filed (Month, Day, Year,	DK. SANDEEL CAUTAM, M.D MARBOR NO SATAL, BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature										
Registrar	JAN 2	0 2000 1	Seneral	19	Loon	Kal						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dafa of Death CALLAWAY Month Yaar **Physician** 16,2000 12:59 AM ESLIE DANUARY /Medical 4a. Facility Nama (If not institution, giva streat and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAMARITAN BALTIMORE CITY HOSPITAL If Undar 1 Yaer If Undar 24 Hrs. 8 Onta of Birth Day V Birthpleca (Stata or Foreign Country)
 N. J. 7. Age (In-yrs. last birthday) **Funeral** 10 M 20 F Days Director Usuel Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. Cify, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f shoother traumatic event, the Medical Examinate result be notified at Md. 1 Yas 2 No Director BALTIMORE N/A 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of What Counfry? 21214 6606 Pioneer Drive USA Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Giva Year or Dafes: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, Whifa, atc. 72 hours after 1 Navar Married 2 Married "naturel", or 1 Yas 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene.

Hyportant: If item 27 is marked other than "nath any injury or other traumatic event, the Median once. Elemantery/Secondary (0-12) College (1-4or 5+) Customer Service Banking 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Sharon Filmore John L. Callaway III 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 9 Rutland Square Unit 3 Boston, MASSACHUSET02118 19a. Informant's Name/Relationship (Type, Print) John L. Callaway III Father 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 XCremation 3 ☐ Ramoval from Stata 1/17/2000 BALTO., MD METRO CREMATORY 4 ☐ Donation 5 ☐ Othar (Specify) Signatura of Funaral Service Licensea 22. Name end Address of Fecility JAMES A. MORTON & SONS F.H., INC Part 1. Enter tha disease, or complication that caused fine deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. 4 Approximate Interval Batwe Onsat and Death **Physician** /Medical Immadiata Cause (Final SEPSIS 4 WEEKS disaasa or condition resulting in daath) Due to (or es a consequança of): Physician/Medical Examiner burial-transit Sequentially list conditions, if any, laeding to immadiata cause. Enter Undarlying Couse (Disaasa or Injury that initieted avents rasulting In daeth) Last and Dua to (or as a consequence of): physician is the burial Dua to (or es a consequenca of): Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown CARDIOMYOPATHY SEVERE DILATED signed to à 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed MULTI-ORGAN SYSTEM FAILURE page 2 1 Yas 20 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case refarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) To 1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? 1 Netural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 3 Suicida 6 Could not be 281. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and due to the cause(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Certifler 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifiar 29c. License number 11402 JANUARY 16, 2000 30. Nama and eddrass of person who completed causa of daath (Itam 23a) (Type, Print) WILLIAM IMBERH, GOOD SAMARITAN HOSPITAL, SOOI LOCK RAVEN BLVD, BALTIMORE

State Registrar 31. Data filed (Mgntb, Cay, Year) 2000

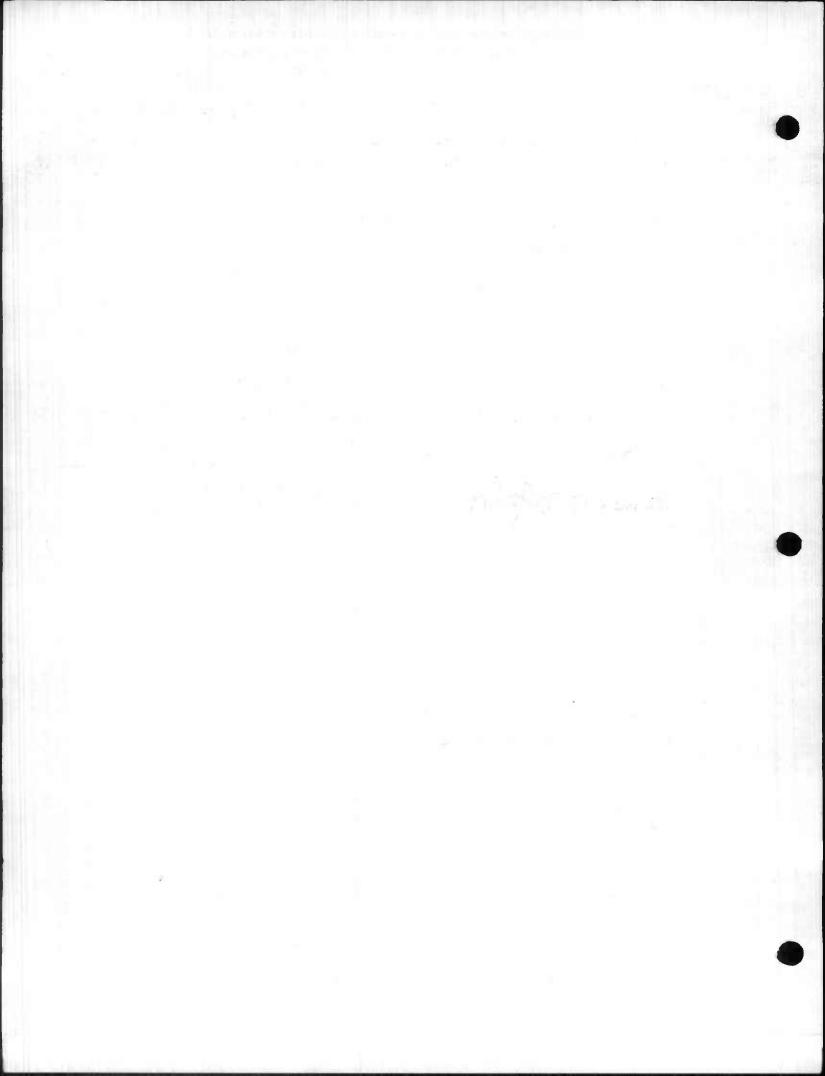
32. Hegistrar's Signature G. Sports

MD 21239

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Tima of Death **Physician** 18, 2000 11:30 AM January Howard John /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9534 Lyons Mill Road Owings Mills Baltimore Dire

Baltimore, Maryland 21215-0020

Physi Exam

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	5. Social Security Number	6. Sex		rrs. lest birthday)		r 1 Year		24 Hrs. Min.	8. Dete of B (Month, D	irth Veer	9. Birthplaca (Stete or F
	216-09-4976 Usual Residence of Decedent	1⊠M 2□	87 87	Yrs.	Months	Deys	Hours	PVIII1,	March	4, 1912	Pennsylvani
ľ	10a. Stete 10b. County	у	10c.	City, Town or Lo	ocation						10d. Inside City I
	Maryland Balt	imore		Owings 1	Mills						1 ☐ Yes 2
	10e. Street and Number				10f. Zip	Code				10g. Citizen of 1	What Country?
1	9534 Lyons Mi	11 Road			2	1117				United	States
	11. Merital Status	12. Wes	Decedent Ever in ad Forces?	n U,S. 13.	Wes Dece	dent of H	lispanic Or en, Mexica	ngin? (Sp	ecify Yes or N Rican, etc.)	o- 14. Rac	ce - American Indien, ck, White, etc.
	1 ☐ Never Married 2 ☑ Mer 3 ☐ Widowed 4 ☐ Divorced	If Ye	Yes 2 🕅 No s, Give or Datas:		1□ Yes	2 💢 No	Specify	:		Specify	white
ŀ	15. Deceder (Specify only highe	nt's Education	eted)	(Give	dent's Usu- kind of wo	rk done	during mos	st of work	ing	16b. Kind of 8	usiness/Industry
	Elementery/Secondery (0-12) 8th Grade		ege (1-4or 5+) -0-		n Bro			1 Dr	illers	Self-E	mployed
ľ	17. Fathar's Nama (First, Middle,	, Last)					18. Moth	er's Nem	e (First, Middle	e, Maiden Sumen	ne)
	George Meade	Dillon					Reb	ecca	Sad1	er	
Ì	19a. Informent's Neme/Reletions	ship (Type, Print)	19b. Meili	ng Address	s (Street	end Numb	er or Rui	ral Route Num	ber, City or Town,	, Stete, Zip Code)
	Virginia M. Di	11on - V	Wife	9534	Lyon	s Mi	11 R	ad;	Owings	Mills,	Maryland 211
Ì	20e. Method of Disposition		20	b. Plece of Dispo cametery, cre	sition /Ne	me of		1	Dete	Y	City or Town, State
	1 Burial 2 □ Cremetion 4 □ Donetion 5 □ Other (5							7 1/1	21/2000	Woodlass	m, Maryland
ŀ	21. Signature of Funerel Service			2	2. Name ar	nd Addre	ss of Facil	itv			
l	Er Da	W 6	0		Lorin	g By	ers I	uner		ectors,	
	1 your on	. De	12 D								Maryland 21
	23a. Pan1, Enter the diseese, o shock, or heert feilure. Lis	r complications t it only one cause	thet caused the do	eeth. Do not en	ter the mod	de ot dyin	ig, such as	cardiec	or respiratory	arrest,	Approximate Intervsi Betwee
			∞	1 1	,		1	. 1	+		Onset and Dee
	Immediate Ceuse (Finel disease or condition		11/6	fas fax	lic.	Ca	PY	ofte	eli		YY
	resulting in deeth)	a	Due to	o (or es a conse	quence ot):						
	Sequentially list conditions	b	Due to	o (or as a conse	quence of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	6	Due to	o (or as a conse	quence of):						
	cause. Enter Underlying Ceuse (Diseese or injury that initiated events	b									
	Ceuse (Diseese or Injury	b		o (or as a consec							
	cause. Enter Underlying Ceuse (Diseese or injury that initiated events	b c d									
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	Due to	o (or as a consec	quenca of):						
	cause. Enter Underlying Ceuse (Diseese or injury that initiated events	c	Due to	o (or as a consec	quenca of):		en in Pert	1.			ontributs to the causs of d
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to death but not	o (or as a consecution of the unit of the	quenca of):		en in Pert	I.		d tobacco uss co] Yes 2□ No	
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to death but not	o (or as a consecution of the unit of the	quenca of):		en in Pert	I.	10	Yes 2 No	3□ Probably 4⊠Un
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	Due to	o (or as a consecution of the unit of the	quenca of):		en in Pert	I.	1 [24e. We		3 Probably 4 Un 24b. Were autopsy find available prior to completion of caus
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to death but not	o (or as a consecution of the unit of the	quenca of):		en in Pert	I.	1 [24e. We	Yes 2 No	3 Probably 4 On 24b. Were autopsy find available prior to
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to death but not	o (or as a consecution of the unit of the	quenca of):		en in Pert	I.	24e. We	Yes 2 No	3 Probably 4 Un 24b. Were autopsy find available prior to completion of caus
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditi	2	Due to death but not	o (or as a consecution of the unit of the	quenca of):				24e. We	yes 2□No s an eutopsy formed?	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death?
	cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditt	al Hospitel	to death but not Myrof	o (or as a consecution of the unit of the	quenca of):	cause giv	26. Piac	e of Dee	24e. We per	yes 2□No s an eutopsy formed?	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yas 2 No
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions are injury that initiated events resulting in death) Last 25. Wes case referred to medical axaminer? 1 Yea 2 No 27. Menper of Deeth	al Hospitel:	Due to to death but not T H Y C T Deteof Injury	resulting in the u	quenca of):	cause giv	_26. Piac er: 4 □ N	e of Dee	24e. We per 1 Lth (Check only ome 5 & Re:	S an eutopsy formed?	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No
	cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions as a miner? 1 Yea 2 No 27. Menper of Deeth 1 Netural 5 Pandid	al Hospitel:	to death but not	resulting in the u	quenca of):	cause giv	_26. Piac er: 4 □ N	e of Deel	24e. We per 1 Lth (Check only ome 5 & Re:	S an eutopsy formed? Yes 2 No	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditi 25. Wes case referred of medical axaminer? 1 Yea 2 No 27. Menper of Deeth 1 Netural 5 Pandid	al Hospitel: 28a. I gigetion Inot be mined 28e. F	Due to to death but not T H Y C T Deteof Injury	resulting in the understanding	inderlying c	Oth	26. Piac er: 4 □ N y at k?	e of Deel	24e. We per 1 Lith (Check only ome 5 Ae: 28d. Describe 28f. Location	Yes 2 No s an eutopsy formed? Yes 2 No ene) sidence 6 Other how injury occur	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions axaminer? 1 Yea 2 No 27. Menper of Deeth 1 Netural 5 Pandianest 2 Accident Invest 3 Suicide 6 Could determ	al Hospitel: ng igetion not be mined 28e. [Due to to death but not T T T I patient Dete of Injury Month, Dey Year Pleca of Injury - A pullding, etc. (Spe	resulting in the use of the sectify) of the section	nt 3 DC	DA Oth	26. Piac er: 4 □ N y at k? Yas 2 □	e of Deel ursing Ho	24e. We per 1 Lith (Check only ome 5 Li Rei 28d. Describe City or To	s an eutopsy formed? Yes 2 No yes 2 No yes 2 No yes 6 Ott sidence 6 Ott show injury occur (Street end Numiown, Stete)	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No ner (Specify) rred
	25. Wes case referred of medica axaminer? 1 Yea 2 No 27. Menper of Deeth 1 Netural 5 Pandi invest 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifylir	al Hospitel: 1	to death but not To death but	resulting in the use of the section	nt 3 DM	Oth	26. Piace et al. N y at k? Yas 2	e of Deei ursing H	24e. We per 1 L L L L L L L L L L L L L L L L L L	S an eutopsy formed? I Yes 2 No ene) sidence 6 Ott how Injury occur (Street end Numi own, Stete)	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No ner (Specify) rred
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions as a miner? 25. Wes case referred to medical as miner? 1 Yea 2 No 27. Menper of Deeth 1 Netural 5 Pandia invest 3 Suicide 4 Homicide 29a. Certifier 1 Certifyling (Check only 2 Medical Medical cause)	al Hospitel: ng igetion Inot be nined 28e. [ng Physician: Tit Examiner: On t and	Due to to death but not To de	resulting in the understanding	nt 3 DO	DA Oth 28c. Injur Wor 1 y, office et the tin, in my o	26. Piace 26. Piace yat k? Yas 2 ne, date ei	ursing Ho	24e. We per 1 Check only ome 5 Re: 28d. Describe 28f. Location City or 7 cases and due to the red et the times	San eutopsy formed? I Yes 2 No Pres 2 No	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yas 2 No ner (Specify) rred ber or Rural Route Number anner as stated.
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions are invested in the conditions of the c	al Hospitel: ng igetion Inot be nined 28e. [ng Physician: Tit Examiner: On t and	Due to to death but not To de	resulting in the use of the section	nt 3 DO	DA Oth 28c. Injur Wor 1 y, office et the tin, in my o	26. Piace 26. Piace yat k? Yas 2 ne, date ei	ursing Ho	24e. We per 1 Check only ome 5 Re: 28d. Describe 28f. Location City or 7 cases and due to the red et the times	San eutopsy formed? I Yes 2 No Pres 2 No	3 Probably 4 On 24b. Were autopsy find available prior to completion of cause of death? 1 Yes 2 No ner (Specify) rred anner as stated. and due to the cause(s)

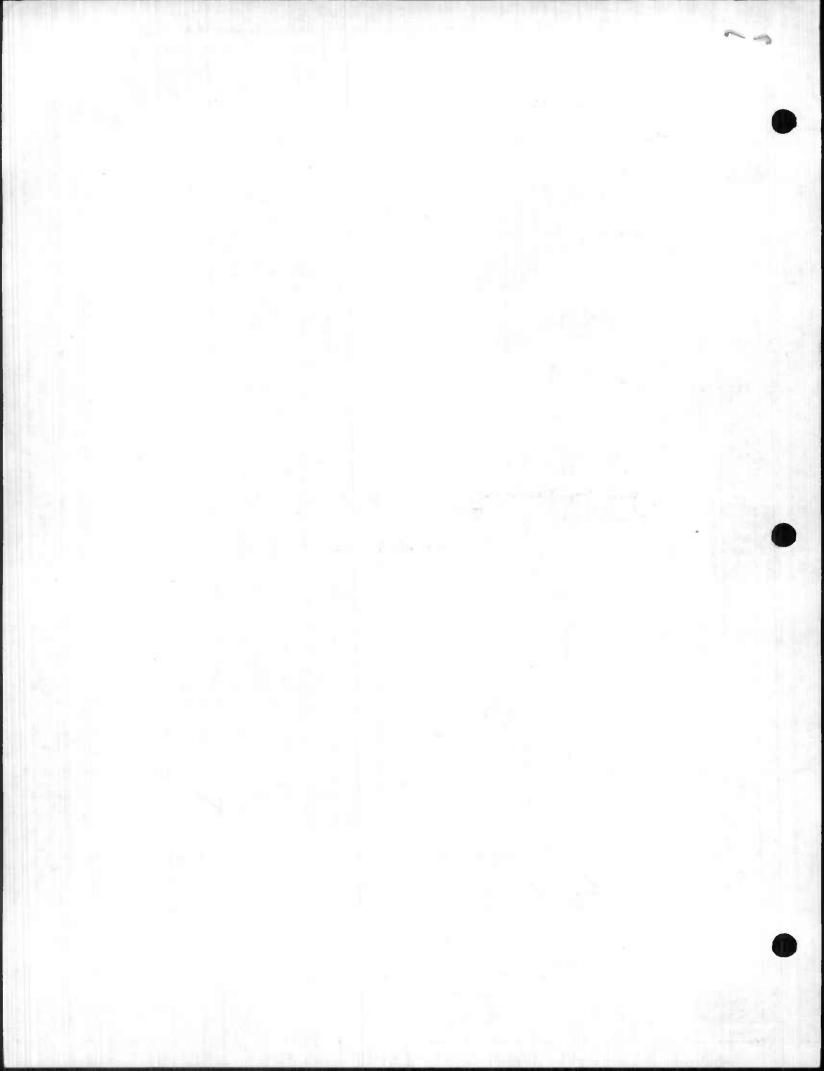
State

Registrar

31. Dete filed (Month, Dey, Year)

JAN 2 0 2000

32. Pegistrer's Signature



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amendn item 17,18 per fh G780 2/4/00 vg Reg. No. dent's Name_(First, Middle, Last) 3. Time of Death 2. Date of Death January 18 8.35 PN Dunn Charles 2000 4a Facility Name (If not Institution, give street and number) or Location of Death 4c. County of Death Harbor Hospital Center Baltimore N/A H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Months 219-16-5733 Maryland Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Arsan Avenue 21225 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Å I Yes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tow Truck Operator Self-Employed 18. Mother's Neme (First, Middle, Maiden Sumame) Seabrease 17. Father's Name (First, Middle, Last) Thomas Andrew Dunn Thomas W. Dunn Goldie Elizabeth Seabreeze 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Arsan Avenue Baltimore, Maryland 21225 Frances I. Dunn (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 1/24/00 Crownsville, Maryland McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licenses Kevin E. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Distress Syndrome Immediate Cause (Final disease or condition resulting in death) weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 2 2 No 1 Yes 20 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funera

à

Completed

Be

Funeral

Director

230-7

b

Мести 23а

"natural", or

Hygiens. other then "naturn ent, the Medical I

Pages 1 and 2 should be fill ment of Health and Mental Health and Mental Health and Mental Health lary or other traumatic event

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner sician and burial-transit physician the buriel Physician/Medical 980 signed by the e ò Completed certificate Be Medical Certification: To this After

The law requires that the death certificate be executed or Attanding Physiolen: 24 hours effer death. filled in by Hospital

completely within 2 \$ 0

State

Registrar

29b. Signeture and Little of certifies Motorard Bole

25. Was case referred to medicat axaminer?

1 Yes 2 No

27. Manner of Death

1 DiNeturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Hospitel:

1 Dinpatient

28a. Dete of Injury (Month, Day Year)

29c. License number RESODO

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

1 Yes 2 No

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

January 18, 2000 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print)
Mohanad Bakleh, MD 3001 South Hanover Street, Baltimore, MD 21225

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

31. Date filed (Month, Day, Year)

JAN 20 2000

5 Pending

investigation

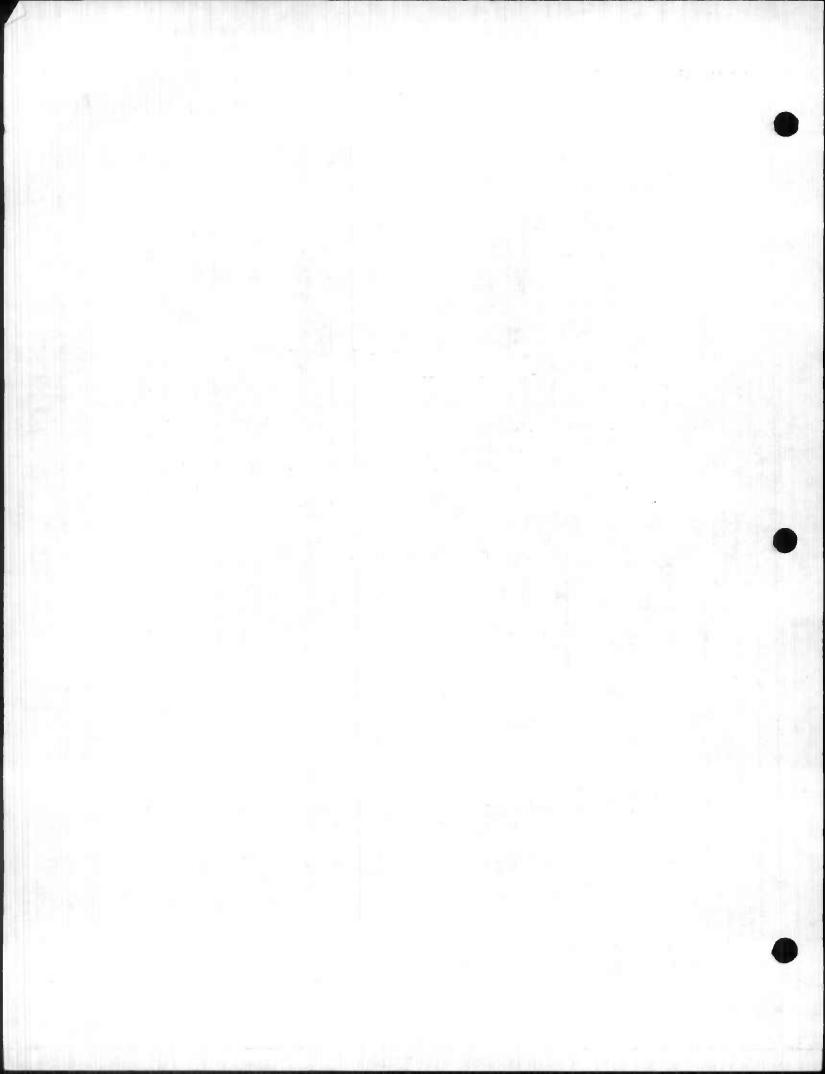
6 Could not be

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last, 2. Dete of Deeth 3. Time of Death Month 4e Facility Name (If not Institution, give street and number) January 17, 2000 nam 4b. City, Town, or Location of Deeth 4c. County of Deeth reneral ULYMORE 1f Under 24 Hrs. 8.1 aryland DITAL If Under 1 Year 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. 9. Birthplece (State or Foreign Country) 4 1 Dete of Birth (Month, Dey, Yeer) Months Deys N.C. 244-52-940 Usuet Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Ma ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Hvenue 21215 vedere 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 Merried 1□ Yes 2□ No Specify. Black Specify. 3 Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oudon Etementery/Şecondery (0-12) College (1-4or 5+) Sea Mstress 2th grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) tha 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2758 19e. Informent's Neme/Relationship (Type, Print) =Sister 809 Walle Forast Chalk W.C Elizabeth Lones sad 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e, Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State Kandallstown, mg 4 Donation 5 Other (Specify) ank 21. Signatur of Funeret Service License 22. Name and Address of Facility yaran Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardlec or raspiratory errest, heart feilure. List only one cause on each line. Ho, Mel Avenue Approximate Intervet Batween Onset end Death Immediete Cause (Finel diseese or condition resulting in deeth) Oue to (or es e consequence of) Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy tindings aveilebte prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 P No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 2 No 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Box 68760. Division of Vital Records, P.O.

the attending physician and thed for use as the bunal-transit law requires that the death certificate be executed signed by the aid be datached for peed page 2 has To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica director, funeral filled in by completely

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

þ

Completed

Be

20

Certification:

Medical

4 Homicide

(Check only one)

31. Dete filed (Month, Dey, Yeer)

29e. Certifier

29b. Signa

Funeral

Director

Nem 27 is marked other than "naturel", or Nems 23a or 28a-f show other treumstic event, the Mod call Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If item 27 is marked other than "any Injury or other traumatic event, the Monte.

Physician /Medical

Examiner

with the Marylend

filed within 72 hours after death

State Registrar

Anandorkershnan

re and title of certifier

JAN 2 n 2000

D290 -

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) 29d. Dete signed (Month, Dey, Year)

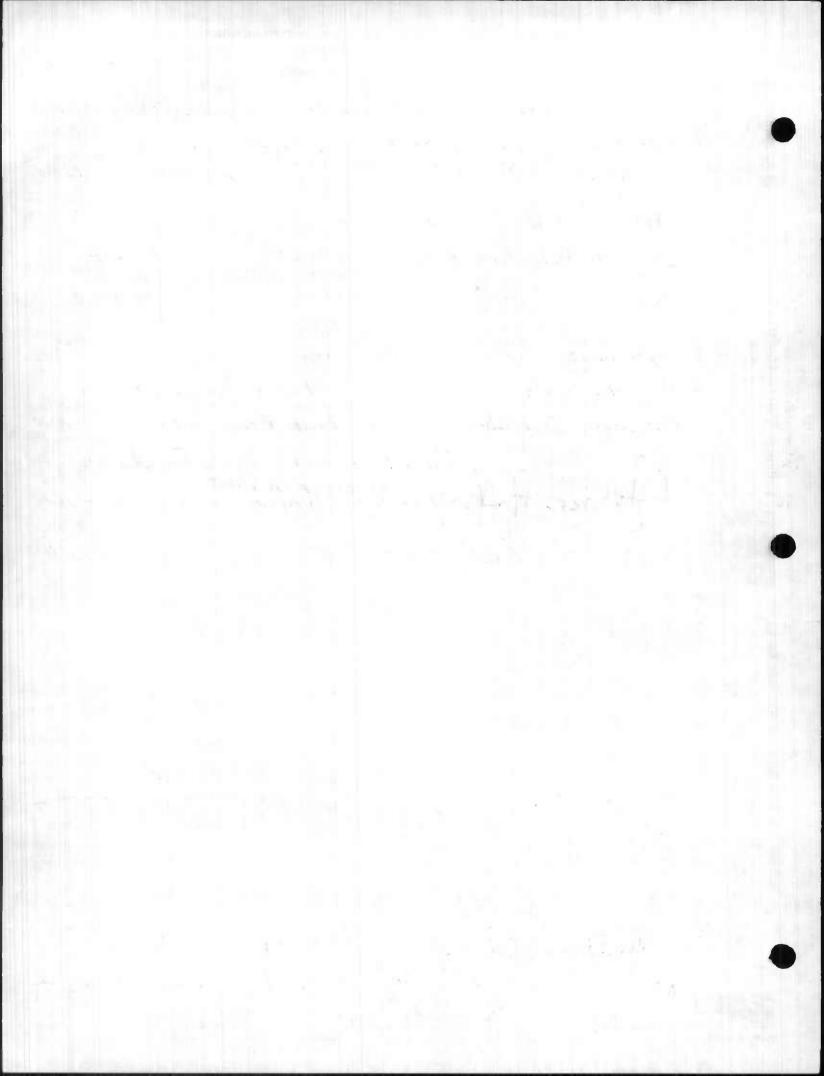
32: Registrer's Signature

f Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceusa(s) end manner as stated.

18/00

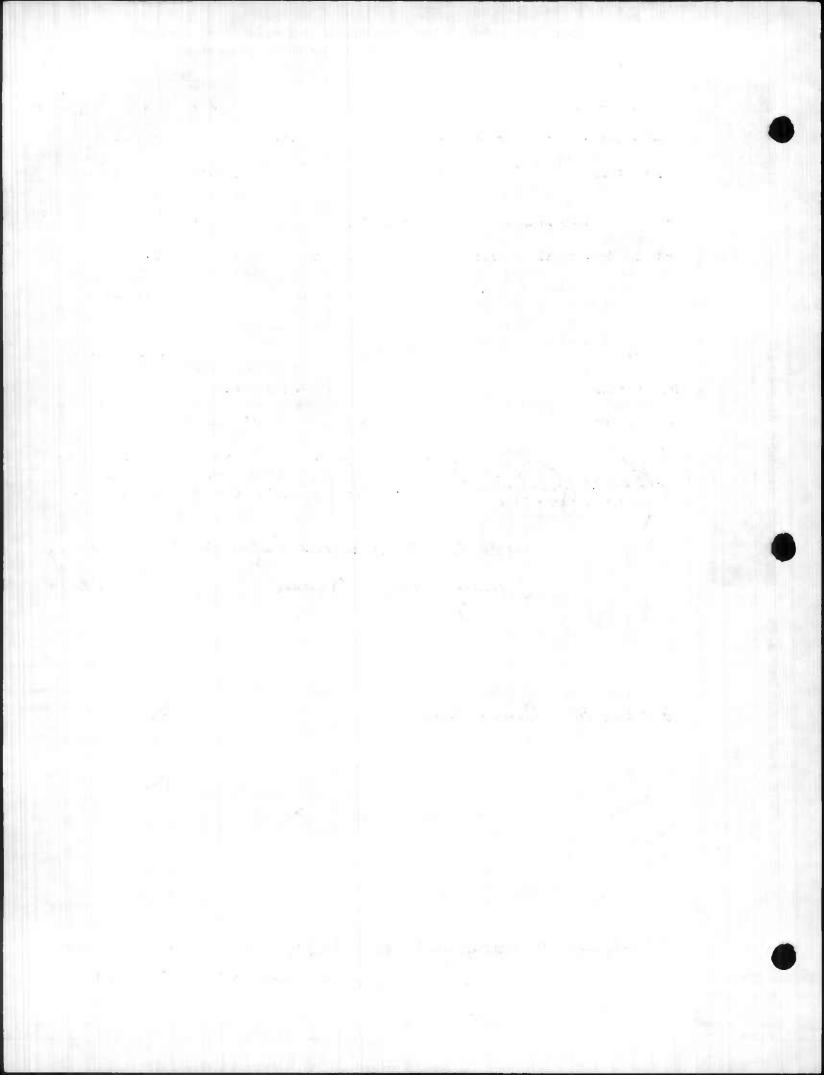
General

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) m.D.



State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 7 4

				Certif	ficate of	Death		Reg. No.	01214
	Physician	1. Decedent's Name (First, Middle, Last) Dortha O. Dunn					2. Data of De Month Januar	eath	Yeer S AC A
	/Medical Examiner	4a Facility Nema (If not institution, give stre Chesapeake Manor		1th Car	1	4b. City, Town, Arnol	or Location of Deat	,	of Death Arundel
	Funeral Director	210.09.4317	7. Aga (In yrs. le		Under 1 Yaer lonths Days		in. (Month, De	th ly, Year) 4, 1912	9. Birthplece (State or Foreign Country) Virginia
	the Maryland 28a-f show sofflied at	Usual Rasidanca of Decedant 10e. Steta 10b. County MD Anne Aru		Town or Location					10d. Insida City Limits 1 ☐ Yes 2XXNo
	aher death with the Maryla or lisms 23e or 28e-f shor miner must be notified at Funeral Director	10e. Street and Number 48 Rol Park Traile			10f. Zip Coda 2110	8		10g. Citizan of W	/hat Country?
020	F 72 4	11. Marital Status 12 1 Nevar Married 2 Married 3 Nation 4 Divorcad	Was Decedent Evar in U,S Armed Forcas? 1 ☐ Yas ※XXNo If Yas, Giva Yaar or Datas:		S Decedant of It as, specify Cub		(Specify Yas or No arto Rican, atc.)		a-Amarican Indian, k, Whita, atc. white
15-0	naturalisadical	15. Decedant's Educat (Spacify only highast grada c		16a. Decedant (Give kind	d of work dona	during most of i	working	16b. Kind of Bu	sinass/Industry
21215-0020	od within 72 ho Ygiene. Ner than "naturn It, the Medical J Completed	Elementery/Secondary (0-12)	Collaga (1-4or 5+)	Cleric	NOT usa retire cal	(d)		Social	Security
	BI 8 6	17. Fathar's Nama (First, Middla, Last)				18. Mothar's I	Nama (First, Middle		
Maryland	Menta Menta Barked affices	John Osborne				Molli	e Kenned	7	
an	and a	19a. Informant's Name/Raiationship (Type	, Print)				Rural Route Numb		
111	and and	Velma G. Dill				Road, Li	nthicum,		
Baltimore,	ariment of H ortant: If iten injury or oth	20a. Mathod of Disposition 1 Naurial 2 Crametion 3 Ran 4 Donation 5 Other (Special 21. Signature of Francis Special	novel from State car	n Haven 22. Na	Cemete	ry	1/22/20 FINK FUN	00 Glen 1	City or Town, Stata Burnie, MD E. PA
ä	Page 4	Kelly Gregory	Fink				W, Glen		
	Physician /Medical	23a. Par Enter the disaesa, of complica short or heart feilure. List only ona Immediata Causa (Final	tions that caused the deeth.	Do not enter the	he mode of dyi	ng, such es card	faret	rrest,	Approximate tritarval Between Onsat and Death
	Examiner :	disease or condition resulting in death)	A cute Due to for	as y copyequen	nce of):	neere	0		red
68760,	certificate be executed nding physician end use as the burial-transit	Sequentially list conditions, if eny, laading to immediate causa. Entar Indarlying Causa (Diseasa or Injury that Initiated evants rasulting in death) Last	and to (or	as a consequen	nce of):				
Box 68	CF 00	L a.	***		22				
	be death he atter ed for u	Part II. Other significant conditions contril	outing to death but not resul	Iting In the under	rlying causa gi	ven in Part I.	23b. Did	tobacco use con	tribute to the cause of death?
Is, P.0	requires that the death cent een signed by the attendin hould be detached for use eted by Physician/N	Vaseular I)ementio		- 1			Yes 20 No	3 ☐ Probably 4 ☐ Unknown
Records,	aw requisite been 2 should							an autopsy ormed?	24b. Wara autopsy findings svailable prior to completion of causa of death?
E	The page						1 🗆	Yes 2 No	1 ☐ Yas 2 ☐ No
Vital	Physician: The law this certificate has ral director, page 2 To Be Comp	25. Wes case reterred to medical examinar? 1 Yes 2 No Hos	pital: 1 ☐ inpatient 2 ☐ E	R/Outpatient	3□ DOA Ot	har:	Deeth <i>(Check only</i> g Homa 5 ☐ Ras		ar (Specify)
n of	£ 5 m		T	28b. Tima of Injury	28c. fnju Wo	ry at		how injury occurr	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	2 Accidant invastigation 3 Sulcida 6 Could not be determined	28a. Pleca of injury - At hon building, atc. (Spacify)	ma, farm, straat,	1]Yas 2□No		(Street and Number wn, Stata)	er or Rural Routa Number,
	he Hospita in 24 hours he Funeral pletely fille		en: To the best of my know : On the basis of axamination and mannar stetad.						
	vithir Vithir Comp	29b. Signature and title of certifier	Attending	bocter	29c. Lican		4		(Month, Day, Year) $9-2000$
	25 10	30. Neme and eddress of person who comp C. V. CYR IAC. M.D 31. Deta tiled (Month, Day, Year)	pleted causa of daeth (Item)	23a) (Type, Prin	11) 2 bw4	PASA	DENA	mD 2	(122
	State	31. Deta tiled (Month, Day, Year)	32. Registrer's Signatu	ure 4	Ina	W.i	,		

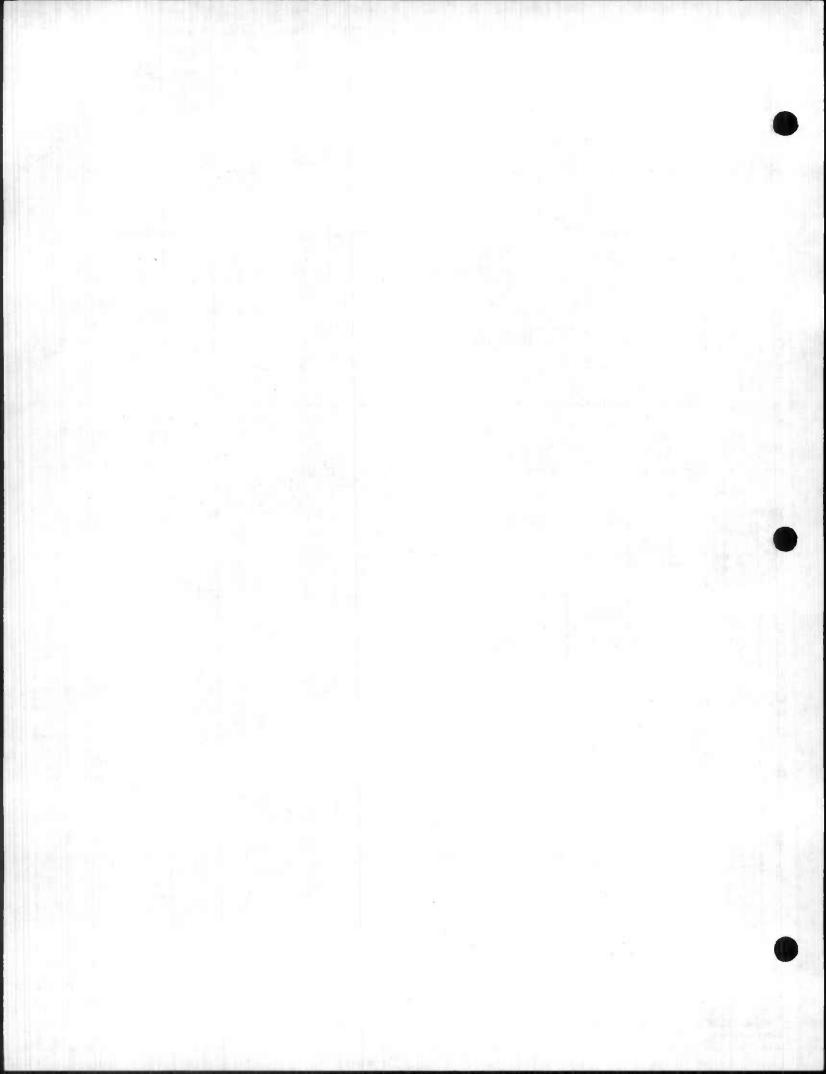


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** EDNA LOUISE ELLIOTT JANUARY 18 2000 5:30 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE HAMMONDS LANE BROOKLYN PARK ANNE ARUNDEL CO. If Under 24 Hrs 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Hours Days 1□ M 2♥ F Months 89 212-36-7950 Director Maryland Usuel Rasidence of Dacedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yas 2 No Director 280-1 Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Norms 23a 3909 Brooklyn Avenue 21225 U.S.A. Funeral 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. filed within 72 hours after 1 ☐ Yes 2 No 1 Nevar Merriad 2 Merried Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 ☑ No Specify: by 3 ☑ Widowed 4 □ Divorced Yeer or Datas: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiene. other than Elamantary/Secondary (0-12) College (1-4or 5+) 9th n Homemaker Home 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Edward Smith Lillian Danielsen 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joan Rohrback (Daughter 752 Fawn Elm Road Severn, Maryland 21144 Item 27 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 🔾 Burial 2 Cramation 3 Ramoval from State = 8 4 ☐ Donation 5 ☐ Othar (Specify) Glen Haven Memorial Park 1/21/00 Glen Burnie, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Pert Y. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) 3 of 64 eumony Examiner Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): The law requires that the death certificate be execu physician a Box 68760, Physician/Medicai Dua to (or as a consequence of): igned by the attendin be detached for use Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1□ Yas 1 Yas 2 No Division of Vital or Attending Physician: funeral director, 25. Was casa rafarred to medical axaminar? 8 26. Place of Death (Check only one) Hospital: Other: 4 Artursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 (Hatural 5 Panding 1 Yes 2 No 24 hours after death. invastigation 2 Accidant 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifian 1 🖺 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. Within 2 9 29b. Signatura and Him of certifian 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Nama and addrass of persen who complated causa of death (ttem 23a) (Type, Print) 901 MB alo

DHMH 16 Rev 6/95

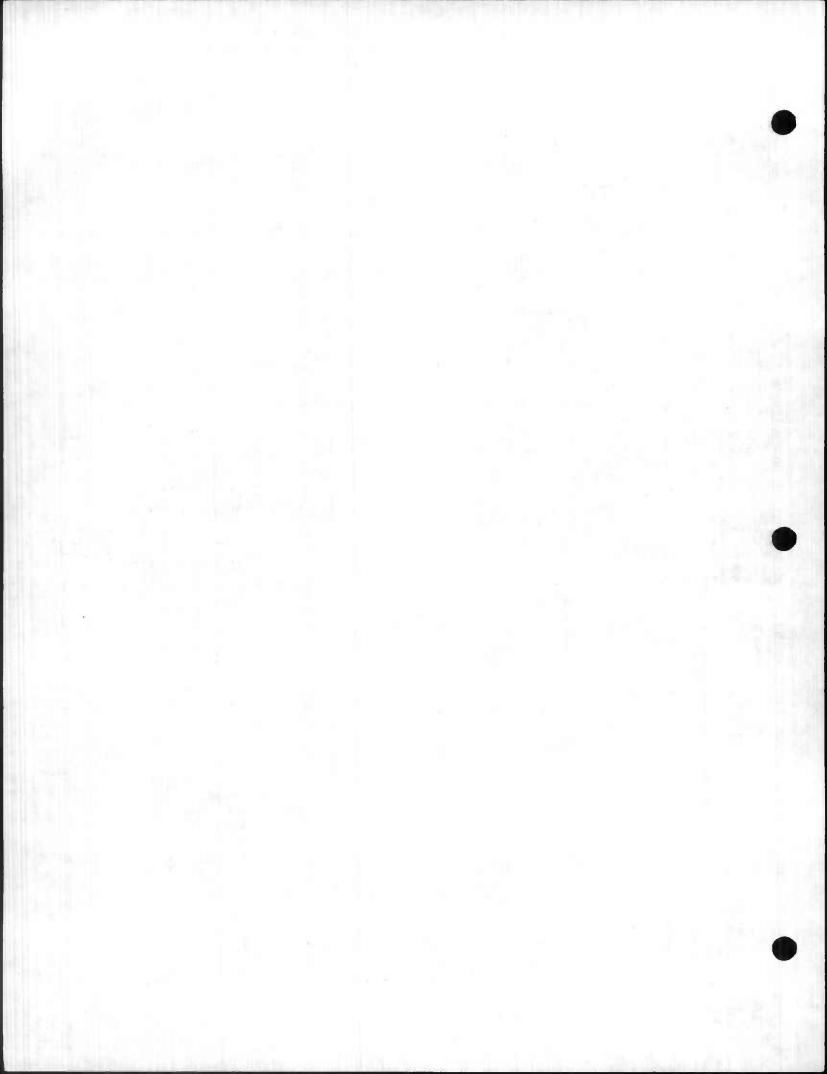
State Registrar 31. Data filed (Month, Day, Year)

32: Registrar's Signatura



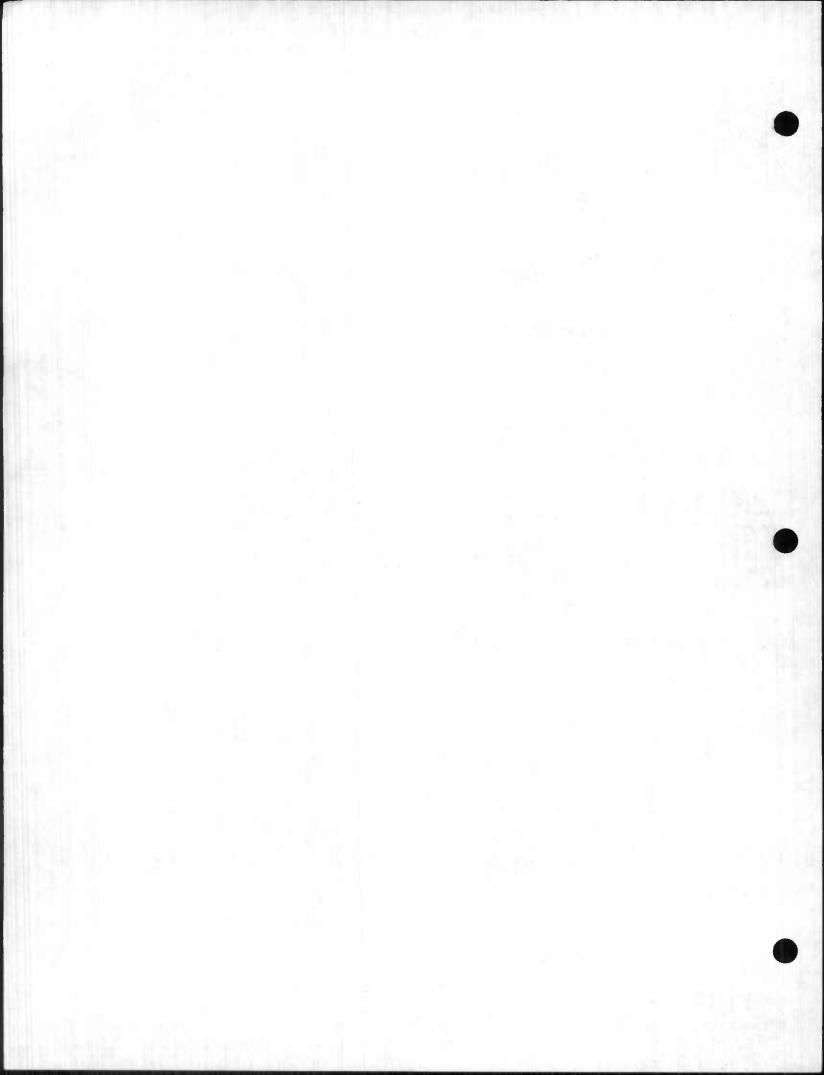
State of Maryland / Department of Health and Mental Hygiene

			(Certificate	of Death	R	eg. No.	01276
	1. Decedent's Name (First, Middle, L	est)				2. Date of Dea	th	3. Time of Death
Physician /Medical	HAZEL GERTRUD	E ERBE				JANUAR	Y 17 2000	
Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location of Death	4c. County of D	
	GENESIS ELDERCA	RE LIBERTY	ROAD		RANDALLS	TOWN	BALTIMO	RE COUNTY
Funeral Director		Sex 7. Age	(In yrs. last birth	Months D	ear If Under 24 H ays Hours M		Year)	Birthplace (State or Foreign Country) aryland
8 *	Usual Residence of Decedenf 10a. State 10b. County		10c. City, Town	or Location				404 Install Oth Line
ation ad at		0-						10d. Inside City Limits 1 ☐ Yes 2√ No
or 28s-f s be notified Director	Darcano	re co.	Ball	imore		1.		21
	7930 Johnnycake	Road		10f. Zip Co	244	1	0g. Citizen of Whaf USA	Country?
urs after de sir, or lleme Examiner.n by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N if Yes, Give Year or Dates;		13. Was Decedent If Yes, specify 1 ☐ Yes 2 ☐		(Specify Yes or No- erto Rican, etc.)	14. Rece - A Black, W Specify: W	
State State	15. Decedent's I (Specify only highest g		16a. D	ecedent's Usual O	ccupation one during most of w	working	16b. Kind of Busine	ss/Industry
ed within 72 hours at yolens. we than 'natural', or it, the Medical Exam Completed by I	Elementery/Secondary (0-12)	College (1-4or 5-		ife. DO NOT use r	etired)			
	6	00		Sales pe	rson		Hochild	's
Be well a	17. Father's Name (First, Middle, Las	1)			18. Mother's N	lame (First, Middle, I	Maiden Sumame)	
To To	Andrew Sank				Georg	eanna Casi	key	
man yiella d 2 should be lile th and Mental Hy 7 is marked othe traumatic event	19a. Informant's Name/Relationship		19b. N	Aailing Address (S	reet and Number or	Rural Route Number	, City or Town, State	e, Zip Code)
* 6 E N P	Gilbert E. Erbe	(Son)	9			Baltimor	e, Md. 21	244
of the second	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	TRamqual from State	20b. Place of D cemetery,	risposition (Name of crematory or other	place)	Dete	20c. Location - City	or Town, State
Pag ment ary o	4 Donation 5 Other (Spec		Glen F	laven Mem	orial Par	1/20/00	Glen Bur	nie, Md.
Detruit. Pages 1 Department of He Important: If her and injury or oth	21. Signature of Funeral Service Lice	//	11	22. Name and A McCully	Polymiak	Funeral 1	Home P.A.	
dist	23a. Part1. Enter the disease, or conshock, or heert feilure. List only	nolications that caused	To death Do no	130 E	Fort Ave.	Baltimore	Md. 21	230 Approximete
S	shock, or heert feilure. List onl	one cause on each line	L.	t enter the mode of	dying, such as card	iac or respiretory arr	551,	Interval Between Onset end Deeth
Physician /Medical	Immediate Cause (Final	CENE	RAND	er. A.	1	>===		
Examiner	disease or condition resulting in death)	e. Corre	ONCOURD	WIAM	Acel	DEMI		inte
- T	100 AVE T	Antic	Due to (or as a co	nsequence of):	- 1 -		11 \	100
neit neit					-(A7(1)	10 MBC	CAR DO	YES
physician and is the burishtraneit	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	11 0	ue to (or as a co	nsequence of):				1/10
ficete be experience of physician is the burial	cause. Enter Underlying Cause (Disease or Injury that initiated events	c. Hy	7010	X 160	\sim			1/1-3
ifficete be ng physicie as the bur Aedical	resulting in death) Last	, ,	ue to (or as a co	nsequence of):				
		d						
death cer e ettendin ed for use								
· 0 • 0 -	Pert ff. Other significant conditions				given in Pert I.	23b. Dfd to		uta to the cause of death?
ires that the death cer signed by the ettendir d be deteched for use d by Physician/A	ATRIAL	F1B/21	CCAT	7 CM		1 U Y	ea 2□No 3□	Probably 40 Unknown
The law requires that the sale has been signed by the page 2 should be deteched.	/					24a. Was a perform		b. Were autopsy findings available prior to completion of cause
mpl								of death?
£ 50 0						1 🗆 Y	es 28/No	1 □ Yes 21 No
Physicien: Trithis certificational director, p. T. De C.	25. Was case referred to midical examiner?	Hospital:				Death (Check only on	e)	
Physic rthis o ral dire	1 Yes 31 No	Hospital:		atienf 3 DOA		Home 5 □ Reside		Specify)
ma P mark	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injun (Month, Day	Year) 28b. Tin		Injury et Work?	28d. Describe ho	ow injury occurred	
tel or Attending P in effector: After al Director: After led in by the funer: Certification:	Accident investigation 3 Suicide 6 Could not determine	DB Dlace of India	y - At home, farm	M , street, fectory, of	1 Yes 2 No	28f. Location (Si City or Town	reet and Number or	Rural Route Number,
Certif		Junuary, etc.	(Opeony)			J., J	, =10.0/	
To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner stat	examination and/	leeth occurred at the investigation, in	e time, date and pla ny opinion, deeth oc	ce, and due to the courred at the time, d	ause(s) and menner ate and place, and	r as stated. due to the cause(s)
Me the	29b. Signature and fittle of certifier	4 4 4		29c. Li	ense number	2	9d. Date signed (M	onthy Day, Year)
F 5 F 0	V//t //	MVU	2	D	2033	33	11/8	100
	20 1100	annulated and a	oth (Next DOLL)		1000		1/10/	0
V	30. Name and address of person who	1 10	38	NATES	MBE	RD/	PIKER	nut mi
State Registrar	31. Date filed (Month, Day, Year)	32: Registra	's Signature -	1				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

											Reg. No.			
	1. Decedent's N	lame (First, Middle, Li	est)							2. Date of Dea		Veer	3. Time o	of Death
cian	Louis	se E. H	arr							Jan.	Day 14 20	Year	05	30
dical		e (If not institution, gi		mber)				b. City, To	wn, or Lo	ocation of Death			05.	20
niner		170				1						27/25		
		cd County					r 1 Yeer	If Under	mbia	0.0.1.10:4	Howa	_		
al	5. Social Securit		Sex 1 □ M 2 🟋 F	7. Age (In yrs. 78		Months		Hours	Min.	8. Dete of Birth (Month, Day Aug. 25)	Year	9. Birthp	ilace (State itry) Orado	or Foreig
r	522-36-4	434		70	Yrs.					Aug. 25,	1921	COL	Oraco	
	Usual Residence													
	10a. State	10b. County		10c, Cit	y, Town or Lo	ocation						1	0d. inside (
to	MD	Howard		Col	umbia								1 ₹ Ye	2 N
8	10e. Sfreet and	Number				10f. Zit	p Code				10g. Citizen of	What Cour	itry?	
5			**											
ie i	9143 He	laine Hamlet	-			210					United			
Funeral Director	11. Marital Statu	JS	12. Was Dece	edent Ever in U rces?	,S. 13.	If Yes, spe	ecify Cubi	lispanic Ori an, Mexicai	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White,		
	1 Never M	Married 2 Merried	1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes	2 No	Specify:			Specia	for Table		
2	3 Widowe	d 4 Divorced	Year or D	ates:		100	20110	opouny.			Speci	y: Whit	e	
Completed		15. Decedent's E	ducation		16a. Dece	edent's Usu s kind of wo	al Occup	etion			16b. Kind of B	usiness/in	dustry	
į		Specify only highest gr			(Give	DO NOT u	ork done use retired	during mos d)	t of work	ing				
Ē	Elementary/S	secondary (0-12)	College (1 5+	-4or 5+)	7000	va Dir	~	of 70	had acad	~	The send	i		
	47 Fatharia Nov	ma (First Middle Lee			ASSU	c. Dir	ecui				Educat			
9		me (First, Middle, Las	•							e (First, Middle,	Maidell Surria			
0	Frank		E	vans				Mild	red			Hoag		
	19a, Informant's	s Name/Retationship	(Type, Print)		19b. Meili	ing Addres	s (Street	and Numb	er or Rur	al Route Numbe	r, City or Town	, State, Zip	Code)	
	White (Greene Farr/	huckond		01/2	Iblai	ma II	mich I	h	blumbia,	MD 21045			
	20e. Method of I		IUSUALU	20b. F	Place of Dispo	Helai osition (Ne		muec w	dy C	Date Date	20c. Location		wn. State	
		2 Cremetion 3 [Removal from		cemetery, cre	matory or	other plac	ce)				0.1, 0.		
		on 5 Other (Speci			esapea	ke Cr	cemat	cory	1	-15-00	Beltsvil	le, MD		
	21. Signature of	f Funeral Service Lice	insee		2	2. Name e	nd Addre	ss of Fecili	ty				1-11/	
	b ./	11	1		C	AFA St	ephen	D. Lo	hmen	n P.A.				
	000	ter the disease, or con	ndesty		8	717 Gr	men P	asture	s Dr.	. Baltim	m. MD 2	1286		
	shock, or	heert feilure. List only	one cause on e	ech line.	n. Do not en	iter the mo	de oi dyii	ig, such es	Carulec	or respiratory er	1051,		Approximation Interval Bit	neewse
n												i	Onset and	Deeth
al l	Immediate Cau	eo (Einal												
			~	3 9 TT-		. 7	محال ك	_				1		
	disease or cond resulting in dee	dition	a Cere	bral Va				t	174					
-	disease or cond	dition	· d.	Due to (d	oras a conse	equence of)		t	178	A.		1		
iner	disease or cond	dition	· d.		oras a conse	equence of)		t				1		
ammer	disease or cond resulting in dee	dition (th)	· d.	Due to (d	oras a conse	ion):	t						
Examiner	disease or cond resulting in dee	dition (th)	b. Atri	al Fibi	rillat: or es a conse	ion):	t	13					
cal Examiner	disease or conditions of the second s	dition th) t conditions, to immediate inderlying e or injury ents	b. Atri	al Fibrate (control of the control o	or as a conse cillat: or as a conse on	ion quence of)):	t						
edical Examiner	disease or cond	dition th) t conditions, to immediate inderlying e or injury ents	b. Atri	al Fibrate (control of the control o	rillat: or es a conse	ion quence of)):	t						
Medical Examiner	disease or conditions of the second s	dition th) t conditions, to immediate inderlying e or injury ents	b. Atri	al Fibrate (control of the control o	or as a conse cillat: or as a conse on	ion quence of)):	t						
Medical	disease or conditions of the second s	dition th) t conditions, to immediate inderlying e or injury ents	b. Atri	al Fibrate (control of the control o	or as a conse cillat: or as a conse on	ion quence of)):	t						
Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	dition th) t conditions, to immediate inderlying e or injury ents	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		1.	23b. Did t	lobacco uee s	ontribute to	o the cause	of deat
/wedical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		l.			ontribute to		
Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		l.	23b. Did 1				
by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		I.	10	Yes 3 No	3 Pro	bably 4[Unkno
by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		I.	1 🗆		3 ☐ Pro	bably 4 (Unkno
by Physician/medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		i.	1 🗆	Yes No	3 ☐ Pro	bably 4 [Unkno
by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deat	t conditions, o immediate inderlying e or injury ents (h) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):		i.	1 🗆	Yes No an autopsy rmed?	3 Pro	babty 4 [era autops: allable prio	Unknow / finding r to cause
Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated everesulting in deal	t conditions, to immediate inderlying a or injury ents th) Lesf	b. Atri	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of)):	ven in Part		1 24a. Was perfo	Yes ANO an autopsy rmed? Yes 2 No	3 Pro	era autops: allable prio impletion of death?	Unkno
Be Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Cause (Disease that indicated ever resulting in death of the cause of	t conditions, o immediate inderlying or injury ents (th) Lesf	b. Atri Hype d contributing to de	al Fib Due to (c ertensic Due to (c	or as a consecutive of the conse	ion quence of) quence of) quence of)	cause giv	ven in Parl	e of Deal	24a. Was perlo	an autopsy med?	3 Pro	era autops: allable prio impletion of death?	Unknow / finding r to cause
Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Cause (Disease that indicated ever resulting in death of the cause of	t conditions, o immediate inderlying or injury ents (th) Lesf	h. Atri Hype d. contributing fo de	Due to (c al Fibi Due to (c ertensic Due to (c extensic	or as a consecutive of the conse	ion quence of) quence of) quence of) quence of) underlying	cause giv	ven in Parl 26. Ptac ner: 4 □ N	e of Deal	24a. Was perlo	an autopsy med? /es 2 No	3 Pro 24b. W av cc of	era autops: allable prio impletion of death?	Unknown finding r to cause
To Be Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated ever resulting in deal Part III. Other els 25. Was case reaminer?	t conditions, to immediate inderlying a or injury ents th) Lesf gnificant conditions eferred to medical condents	b. Atri Hype c. Hospital:	Due to (content of the content of th	or as a consection of the cons	ion ion quence of) quence of) quence of) quence of)	cause giv	ven in Parl 26. Ptac ner: 4 □ N	e of Deal	24a. Was perlo	an autopsy med? /es 2 No	3 Pro 24b. W av cc of	era autops: allable prio impletion of death?	Unknown finding r to cause
To Be Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Ceuse (Disease that Initiated eversulting in deal Part II. Other elg. 25. Was case re examiner? 1 Yes 2 27. Manner of Disease That III. Natural	t conditions, to immediate inderlying a or injury ents thi) Lesf gnificant conditions eferred to medical	d. Hyper de Hospifal: 28e. Dete (Monitor)	Due to (c al Fibi Due to (c ertensic Due to (c extensic	or as a consection or a c	ion ion quence of) quence of) quence of) quence of)	cause give	ven in Parl 26. Ptac ner: 4 □ N	e of Deal	24a. Was perlo	an autopsy med? /es 2 No	3 Pro 24b. W av cc of	era autops: allable prio impletion of death?	Unkno
To Be Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated ever resulting in deal Part III. Other els 25. Was case reaminer?	t conditions, to immediate inderlying or injury ents th) Lesf eferred to medical conditions 5 Pending investigation of Could not to Could not the	d. Hospital: 28e. Dete (Monto)	Due to (content of the content of th	or as a consection of the cons	ion quence of) quence of) quenca of): underlying ent 3 D of M	cause giv	26. Ptac	e of Deal	24a. Was perlo	en autopsyrmed? Yes 2 No ons) Jence 6 On owinjury occur	3 Pro 24b. W av cc of 1 (era autops: allable prio mpletion of death? Yes 2(1)	Unknowy finding r to cause
To Be Completed by Physician/Medical	Sequentially list if any, leading to cause. Enter U Couse (Disease that initiated eversulting in deal of the cause in the	t conditions, o immediate inderlying or injury ents (th) Lesf gnificant conditions 5 Pending investigation 6 Could not determine to the country of the cou	d. Hype de la contributing fo de la contributing for de la contribution de la con	Due to (content of the content of th	or as a consection or a consecti	ion quence of) quence of) quenca of): underlying ent 3 D of M	cause giv	26. Ptac	e of Deal	24a. Was perfo	an autopsy med? Yes 2 No ona) dence 6 On one injury occurstreet and Num	3 Pro 24b. W av cc of 1 (era autops: allable prio mpletion of death? Yes 2(1)	Unknown / finding r to cause
Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Indieted eversulting in deal of the cause o	t conditions, o immediate inderlying or injury ents (th) Lesf gnificant conditions 5 Pending investigation 6 Could not determine to the country of the cou	d. Hype de la contributing fo de la contributing for de la contribution de la con	Due to (c al Fibi Due to (c ertensic Due to (c entensic of Injury th, Dey Year)	or as a consection or a consecti	ion quence of) quence of) quenca of): underlying ent 3 D of M	cause giv	26. Ptac	e of Deal	24a. Was perio	an autopsy med? Yes 2 No ona) dence 6 On one injury occurstreet and Num	3 Pro 24b. W av cc of 1 (era autops: allable prio mpletion of death? Yes 2(1)	Unkno
Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Ceuse (Disease that Initiated eversulting in deal Part II. Other elg Part II. Other elg 25. Was case re examiner? 1 Yes 27. Manne of D 1 Nafurel 2 Accider 3 Suicide 4 Homicie	t conditions, to immediate indepring a or injury ents thi) Lesf gnificant conditions split conditions eferred to medical investigation of Could not determined	d. Hospifal: 28e. Dete (Monion be building)	Due to (content of the content of th	or as a consection or a consecti	quence of) ion quence of)	cause gives 28c. Injury, office	26. Ptaco	e of Deal	24a. Was perfo	Yes No an autopsy med? Yes 2 No one one 6 One one injury occu Street and Num vn, State) cause(s) end n	3 Pro 24b. Way cc of 11	era autops: allable prio impletion of death? Yes 2l Yy)	Unkno
Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated eversulting in deal of the cause	t conditions, to immediate indepring a or injury ents thi) Lesf gnificant conditions split conditions eferred to medical investigation of Could not determined	d. Hospifal: Atri Hospifal: 28e. Deta (Monion be building) 28e. Place building hysician: To the iminer: On the building hysician	Due to (content of the content of th	or as a consection or a consecti	quence of) ion quence of)	cause gives 28c. Injury, office	26. Ptaco	e of Deal	24a. Was perfo	Yes No an autopsy med? Yes 2 No one one 6 One one injury occu Street and Num vn, State) cause(s) end n	3 Pro 24b. Way cc of 11	era autops: allable prio impletion of death? Yes 2l Yy)	Unkno / findings / for cause No
edical Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that initiated eversulting in deal of the cause	eferred to medical and investigation of the conditions of the cond	d. Hospifal: Atri Hospifal: 28e. Deta (Monion be building) 28e. Place building hysician: To the iminer: On the building hysician	Due to (c al Fibi Due to (c ertensic Due to (c ertensic Due to (f finite seath but not res of Injury th, Dey Year) of Injury - At h ng, etc. (Specia	or as a consection or a consecti	equence of) ion quence of)	cause gives a ca	26. Ptaco	e of Deal	24a. Was perfo	Yes No an autopsy med? Yes 2 No one one 6 One one injury occu Street and Num vn, State) cause(s) end n	3 Pro 24b. Way cc of 1 (ther (Special urred) namer as s , and due t	era autops: allable prio impletion of death? Yes 2f Yy) al Route Mu stated. o tha cause	Unknown tindings of to
edical Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated eversulting in deal of the cause in the cause	eferred to medical and investigation of the conditions of the cond	d. Hospifal: Atri Hospifal: 28e. Deta (Monion be building) 28e. Place building hysician: To the iminer: On the building hysician	Due to (c al Fibi Due to (c ertensic Due to (c ertensic Due to (f finite seath but not res of Injury th, Dey Year) of Injury - At h ng, etc. (Specia	or as a consection or a consecti	quence of) ion quence of)	cause give	26. Place ner: 4	e of Deal	24a. Was perfo	yes No an autopsy med? Yes 2 No ona) dence 6 On ow injury occu Street and Num vn, Stete) cause(s) end n date end place 29d. Date sign	3 Pro 24b. Way occ of 1 (ther (Special arred) anner as s and due t ed (Month,	era autops: allable prio impletion of death? Yes 2l Yes 2l All Route Mu al Route Mu tated. o tha cause Day, Year)	Unknown v findings r to r to r cause No
To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated eversulting in deal of the cause in the cause	eferred to medical and investigation of the conditions of the cond	d. Hospifal: Atri Hospifal: 28e. Deta (Monion be building) 28e. Place building hysician: To the iminer: On the building hysician	Due to (c al Fibi Due to (c ertensic Due to (c ertensic Due to (f finite seath but not res of Injury th, Dey Year) of Injury - At h ng, etc. (Specia	or as a consection or a consecti	quence of) ion quence of)	cause gives a ca	26. Place ner: 4	e of Deal	24a. Was perfo	Yes No en autopsy med? Yes 2 No ens) dence 6 On ens one injury occu Street and Num vn, Stete) cause(s) end n date end place	3 Pro 24b. Way occ of 1 (ther (Special arred) anner as s and due t ed (Month,	era autops: allable prio impletion of death? Yes 2l Yes 2l All Route Mu al Route Mu tated. o tha cause Day, Year)	Unknown tindings of to
edical Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated eversulting in deal to the cause of the cause	eferred to medical and investigation of the conditions of the cond	Hospifal: d. 28e. Dete (Monion be discontribution) 28e. Place buildi hysician: To the building manual manual discontribution be and manual discontribution.	Due to (c al Fibi Due to (c ertensic Due to (c entensic Due to (c) Due to (c) Part to (c) Due to (c) Due to (c) Part to (c) Due to	or as a consection or as a conse	equence of) ion quence of) quence of)	cause give	26. Place ner: 4	e of Deal	24a. Was perfo	yes No an autopsy med? Yes 2 No ona) dence 6 On ow injury occu Street and Num vn, Stete) cause(s) end n date end place 29d. Date sign	3 Pro 24b. Way occ of 1 (ther (Special arred) anner as s and due t ed (Month,	era autops: allable prio impletion of death? Yes 2l Yes 2l All Route Mu al Route Mu tated. o tha cause Day, Year)	Unkno
edical Certification: To Be Completed by Physician/Medical	disease or concresulting in dee Sequentially list if any, leading to cause. Enter U Couse (Disease that Initiated eversulting in deal of the cause in the cause	eferred to medical and strip of the conditions of immediate inderlying a or injury ents with Less and the conditions of	d. Hospifal: Atri Hospifal: 28e. Deta (Monion be building) 28e. Place building hysician: To the building and manion be completed cause.	Due to (c al Fibi Due to (c ertensic Due to (c entensic Due to (c) Due to (c) Part to (c) Due to (c) Due to (c) Part to (c) Due to	or as a consecutive as	equence of) ion quence of) quence of)	cause gives cause	26. Place ner: 4	e of Deal	24a. Was perfo	yes No an autopsy med? Yes 2 No ona) dence 6 On ow injury occu Street and Num vn, Stete) cause(s) end n date end place 29d. Date sign	3 Pro 24b. Way occ of 1 (ther (Special arred) anner as s and due t ed (Month,	era autops: allable prio impletion of death? Yes 2l Yes 2l All Route Mu al Route Mu tated. o tha cause Day, Year)	Unknowy findings of to cause No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year JANUARY 17, 2000 9:58 AM Pauline T. Goff 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AACOUNT FIEN BURNIE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Pay, May 28, 4RUNDEL 105PITAL No R TH 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) If Under 1□ M 2/7 Months 225.16.3906 81 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 364 Dun Robbin Drive 21146 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ÀXNo If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 Yes XX No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Harbor L. Taylor Bessie Shough 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Goff - husband 364 Dun Robbin Drive, Severna Park, MD 21146 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 X urial 2 ☐ Cremation 3 ☐ Removel from Stete Providence UMC cemetery 1/21/2000 Patrick Sprongs, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Fecility FINK FUNERAL HOME. PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 IT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Hypotension da Due to (or es a consequence of): Hypoxia Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): 4 week Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000No 28 ER/Outpatient 3□ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

þ

Completed

Be

Funeral

Director

288-5

8 238

b

Hygiene.

h and Mental ? Is marked of

of Health a Bern 27 h

5 = 5

SA SE

Pages 1 and 2 should be filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760.

Division of Vital Records, P.O.

pue signed by the at d be detached for this certificata has funeral After

Examiner The law requires that the death certificate be executed Physician/Medical þ Completed Attending Physician: Be Certification: To death. To the Hospital or Attends within 24 hours after death. To the Funeral Director: A completely filled in by the fi

State Registrar

MirzA

Medical

31. Dete filed (Month, Day, Year)

27. Manner of Deeth

1 SoNatural

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammea

28a. Dete of Injury (Month, Day Year)

32. Registrar's Signature

28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29d. Dete signed (Month, Day, Year) 1/18/00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NUSAIRER, NORTH Arunde

28d. Describe how injury occurred

28c. Injury at Work?

1 Cocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 TYes 2 No

To the I



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #5 PER FH G780 2/16/2000 AH 1. Decedegt's Name (First, Middle, Last) 2 Date of Death **Physician** · /Medical 4b. City. Town, or Location of Death Fecility Name (If not institution, give street end number) Examiner Burnie en 9 5. Social Security Number 201 - 79 1949 If Under 1 Ye If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth **Funeral** Days 1 M 2 F Yrs Pennsylvania 1955 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or leams 23s or 28s-f show the Medical Examiner must be notified at Maryland Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 973 Point Pleasant Road 21060 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2/☐ No Specify: Specify: py White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 te marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) RSC Co. Heavy Equipment Mechanic 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Jennie Wilson Thorpe Edward D. Hall 2 permit. Pages 1 and 2 sho.
Department of the sight and A.
Lingortant If flem 27 is mark.
any injury or other re-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 38 Walnut Ave., Dunbar, Penna. 15431 Sheila D. Hall (Ex-wife) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burla! 2 ☐ Cremetion 3 ☐ Removel from State Jan 20, 2000 Baltimore, Maryland Greenmount Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signeture of Puneral Service Licensee Kevin E. 22. Name and Address of Fecility
MCCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner nding physician and use as the bunal-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be exec Box 68760. the ettending physician Physician/Medical Due to (or es e consequenca of) 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by is should be detect 1 ☐ Yaa 2 ☐ No 3 Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of ceuse of death? certificate has 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2□ No 9 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manger of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? Affert 1 Matural 5 Pending investigation death. 2 □ No 1 Yes 2 Accident after death Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as staled. Medical Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated. (Check only one)

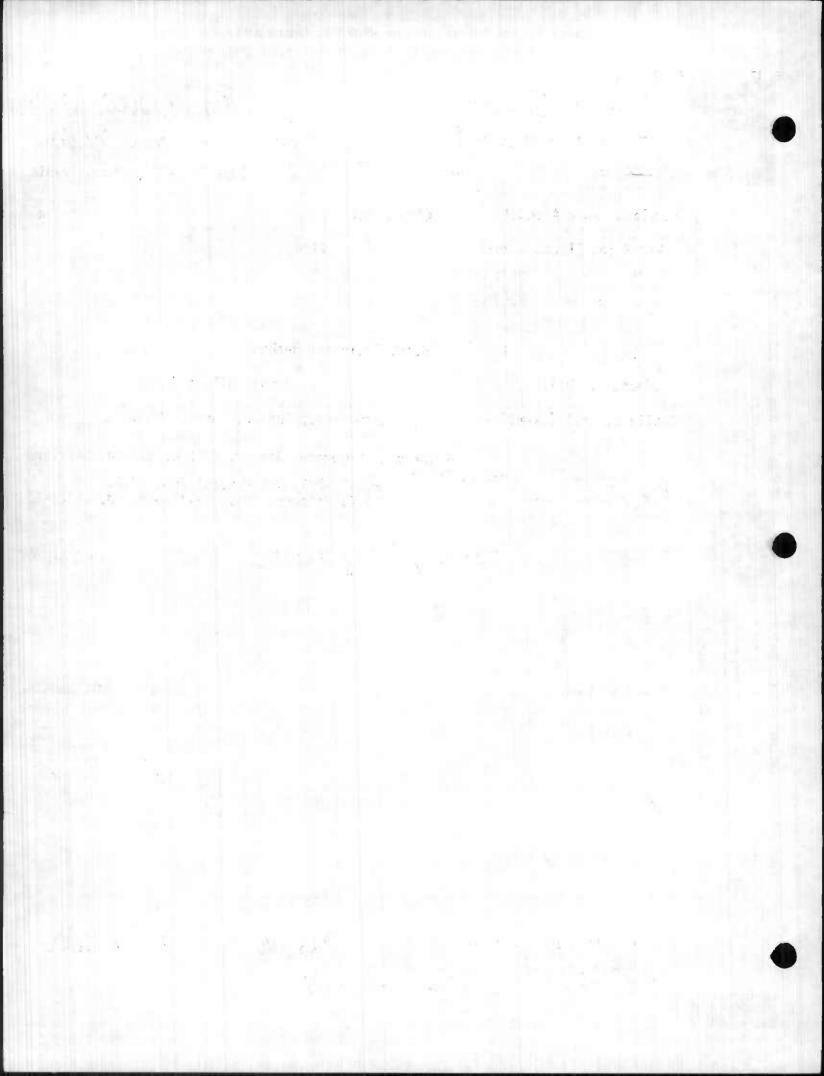
ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar 29b. Signature and title of certifier

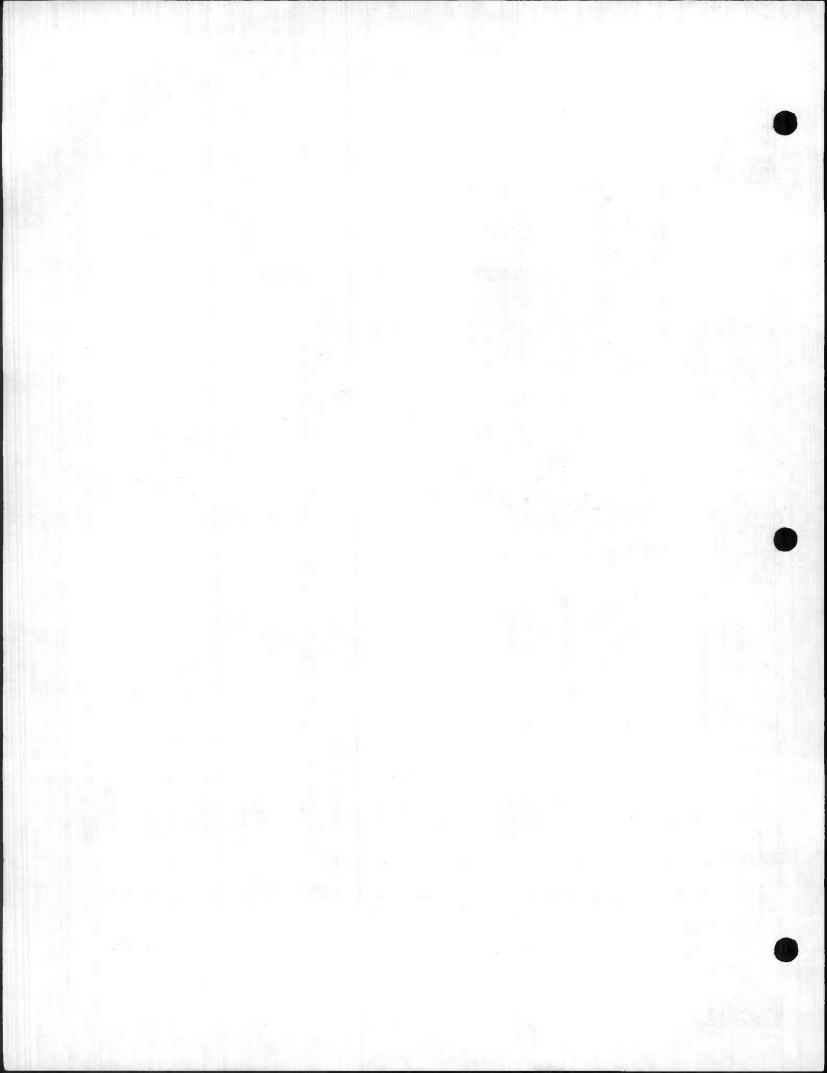
31. Date filed (Month, Dev

30. Name an



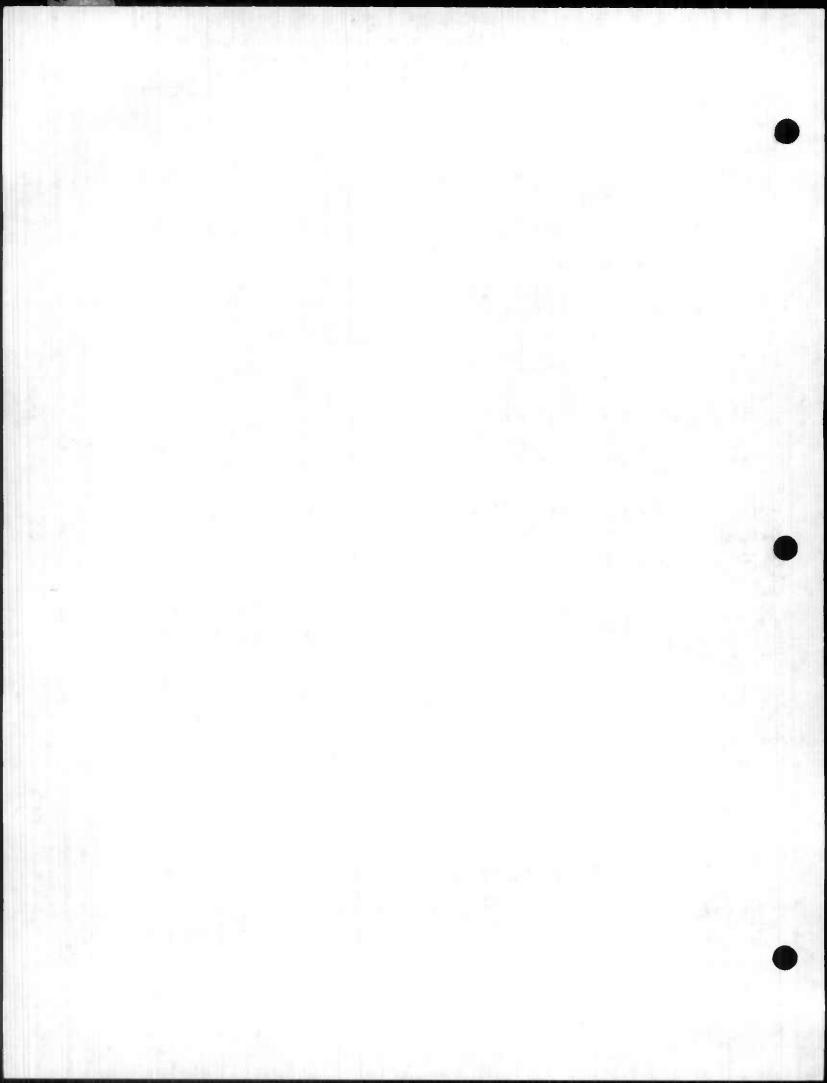
State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 8 0

			Ce	rtificate	of Deatl	h	Re	g. No.	0 1	200	
Dhusisian	Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day	Year	3. Time of Death	3
hysician /Medical	Ralph G. Ingram						anuary		000	2:15PM	
aminer	4a Facility Name (If not institution, give st					Fown, or Locati	ion of Death	4c. County			
	Franklin Woods Nurs			I Miladas 4		timore		Balti			
	5. Social Security Number 220-14-1018 Usual Residence of Decedent	M 2 F	75 Yrs.	If Under 1 Months D	ays Hours	Min.	Date of Birth (Month, Day, 1) ept. 24	1924		e (Stete or Fore	nign
	10e. State 10b. County	10c. C	ity, Town or L	ocation					10d	. Inside City Lim	its
Director	Maryland Baltimore	2	Baltir		4-		140	0		1 ☐ Yes 2 ☑	No
	7321 Chesapeake Roa	nd		10f. Zip Co			10	g. Citizen of V US		7	
by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Wes Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1943		Wes Deceden If Yes, specify 1 ☐ Yes 2 ☒			y Yes or No- an, etc.)	Blac	e - American ck, White, etc : White		
Completed	15. Decedent's Educa (Specify only highest grade		16a. Dece	dent's Usual O kind of work of DO NOT use r	ccupation	ost of working	10	6b. Kind of Bu	usiness/Indus	stry	
HOP	Elementary/Secondary (0-12)	College (1-4or 5+)	life.					_			
	17. Father's Name (First, Middle, Last)			Truck		toda Nama 15	îrst, Middle, Mi		ght Tr	ick	
To Be	John Ingram					rtle		alderi Sumani	16)		
	19a. Informant's Name/Relationship (Type Irene M. Ingram (sp						ltimore			ode)	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	movel from State	ilen Ha	ven Cell Name and A	etery	20	1. 19	oc. Location - Glen Bu Funera	ırnie,	Marylar	nd_
	Mischell.	Staton					Pasader				
iner	shock, or heart failure. List only only only only only only only only	metast	atcc (or as a conse							iterval Between nset and Deeth	
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		or es a conse								
Physician/	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the I	inderlying caus	e alven in Per	*1 I	23h. Did toh	acco usa co	ntribute to ti	ne cause of dea	th?
					o giroir arr ai			2 □ No		3.	
Completed by							24a. Was an perform		availe	autopsy finding able prior to delion of cause ath?	IS
E O							1□ Yes	20 No	101	res 2 No	
Be C	25. Was case referred to medical				26. Pla	ce of Death (C	heck only one	,			
To	examiner? 1 Yes 2 No	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other:	Nursing Home	5 Residen	ce 6 Oth	er (Specify)		
	27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c.	Injury at Work?		I. Describe how	v injury occur	red		
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st ify)	reel, factory, or	fice	281.	Location (Stre City or Town,		er or Rural F	Route Number,	
edical C	29a. Certifier Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my kn r: On the basis of examin and manner steled.	owledge, deat ation and/or in	h occurred et to	ne time, date a my opinion, de	and place, and beth occurred a	due to the cau at the time, dat	use(s) and ma e and place,	nner as stat and due to th	ed. ne cause(s)	
M	29b. Signature and title of certifier	1		29c. L	cense number	r	29	d. Date signe	d (Month, Da	y, Year)	
	-			7	376	12		110	17/20	00	
	30. Name and address of person who com MOHAMAD ALA	pleted cause of death (Ite 3RASH M.	om 23a) (Type,	D-2-0			C BEL	AIR M	10 21	014	
State	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	1			200	410	803	9031	



State of Maryland / Department of Health and Mental Hygiene

Pages 1 and 2 should be illed within 72 hours after death with the Maryland Examiner (Health and Marital Hydrand Examiner (Health and Marital Hydrand Examiner), or flame 23 a or 23 a fact allow for other training training and training for other training and training for other tr	Social Security Number 578-05-8531 suel Residence of Decedent Da. State 10b. County Maryland De. Street and Number 3035 Oak Green Cl. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced (Specify only highes Elementary/Secondery (0-12)	Rose Lorrail give street and number) 35 Oak Green Cit 6. Sex 1 M 20 F Howard Circle, Apt. E 12. Was Decedent I Armed Forces? 1 Yes, Give Yeer or Detes: s Education t grade completed) College (1-4or 5	rcle, Apt. 9 (In yrs. last I 87 10c. City, To	E If Un Montt	Adder 1 Year has Deys E Zip Code	Elli Cotty, Town, or Lot Elli If Under 24 Hrs. Hours Min. Ellicott City 21043 ispenic Origin? (Spr., Mexican, Puerto	cation of Death Cott City B. Dete of Birth (Month, Dey, April 17	Dey 19, 20 4c. County of Year)	Howard Birthplace (State of Country) District of Co 10d. Inside Cl 1 □ Yes
Examiner Family Paper 1 and 2 about be liked within 72 hours after death with the Maryland Director To Be Completed Chart and Martial Hydrau To Be Completed Entitled All 10e 11. 12. 13. 14. 15. 16. 16. 17. 18. 18. 19. 19. 19. 19. 19. 20. 20. 20. 20. 20. 20. 20. 2	Social Security Number 578-05-8531 suel Residence of Decedent be. State 10b. County Maryland De. Street and Number 3035 Oak Green C 1. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L J0 9e. Informent's Neme/Reletionsh	Howard Circle, Apt. E 12. Was Decedent I Amed Forces? 1 Yes, Give Yeer or Detes: s Education t grade completed) College (1-4or 5	87 10c. City, To	yrs. If Un Mont! Yrs. If Un Mont! Dwn or Location 10f. 13. Wes De If Yes, s	Zip Code	Elli If Under 24 Hrs. Hours Min.	cation of Death Cott City B. Dete of Birth (Month, Dey, April 17	4c. County of Year) 7, 1912	Howard Birthplace (State of Country) District of Co 10d. Inside Cl 1 Yes
Director Dispartment of Health and Mental Hygiens The marked of overal the marked of health and	Social Security Number 578-05-8531 suel Residence of Decedent Da. State 10b. County Maryland De. Street and Number 3035 Oak Green C I. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L JO 9e. Informent's Neme/Reletionsh	Howard Circle, Apt. E 12. Was Decedent I Armed Forces? 1 Yes 2 M 1 Yes, Give Yeer or Detes: s Education It grade completed) College (1-4or 5	87 10c. City, To	yrs. If Un Mont! Yrs. If Un Mont! Dwn or Location 10f. 13. Wes De If Yes, s	As Deys E Zip Code scedent of Hispecify Cuba	If Under 24 Hrs. Hours Min. Ellicott City 21043	8. Dete of Birth (Month, Dey, April 17	, 1912	9. Birthplace (Stete of Country) District of Co 10d. Inside Cl 1 Yes nat Country?
Director Dispartment of Health and Mental Hygiens The marked of overal the marked of health and	578-05-8531 suel Residence of Decedent Da. State 10b. County Maryland De. Street and Number 3035 Oak Green C 1. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L	Howard Circle, Apt. E 12. Was Decedent Amed Forces? 1 Yes 2 M H Yes, Give Yeer or Detes: s Education t grade completed) College (1-4or 5	87 10c. City, To	Yrs. Month Own or Location 10f. 13. Wes De If Yes, s	As Deys E Zip Code scedent of Hispecify Cuba	Ellicott City 21043	April 17	, 1912	District of Co 10d. Inside Cl 1 □ Yes nat Country?
Department of health and Memail Pages 1 and 2 ahould be filled within 72 hours after death with the Maryland Department of Health and Memail Hygeria. 10e Complete Enaminer must be notified at a not	Maryland De. Street and Number 3035 Oak Green Colored Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Moroced 15. Decedent (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, Lored 9e. Informent's Neme/Reletionsh	Dircle, Apt. E 12. Was Decedent I Armed Forces? 1	Ever in U,S.	10f.	Zip Code ecedent of Hi specify Cuba	21043		0g. Citizen of Wh	1 ☐ Yes
Department of Health and Mental Highers The Completed other than Tar hours after description and Mental Highers To Be Completed by Fune To Be C	De. Street and Number 3035 Oak Green C 1. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L JO 9e. Informent's Neme/Reletionsh	Dircle, Apt. E 12. Was Decedent I Armed Forces? 1	No.	13. Wes De	Zip Code ecedent of Hi specify Cuba	21043		0g. Citizen of Wh	nat Country?
Department of Health and Mental Highers The Completed other than Tar hours after description and Mental Highers To Be Completed by Fune To Be C	De. Street and Number 3035 Oak Green C 1. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L JO 9e. Informent's Neme/Reletionsh	Dircle, Apt. E 12. Was Decedent I Armed Forces? 1	No.	13. Wes De	Zip Code ecedent of Hi specify Cuba	21043		0g. Citizen of Wh	
Department of Health and Mental Highers The Completed other than Tar hours after description and Mental Highers To Be Completed by Fune To Be C	I. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L	12. Was Decedent I Armed Forces? 1	No.			ispenic Origin? (Sp	ecity Yes or No-		
The property of the property o	(Specify only highes Elementary/Secondery (0-12) 7. Father'e Neme (First, Middle, L JO 9e. Informent's Neme/Reletionsh	t grade completed) College (1-4or 5	16		s ZUINO	Specify:	Rican, etc.)		- American Indien, White, etc. White
The property of the property o	JO 9e. Intorment's Neme/Reletionsh		i+)	Sa. Decedent's U (Give kind of life. DO NO	work done of Tuse retired	ation during most of work toll Assistant	ing	16b. Kind of Bus	Banking
property and the property of t	JO 9e. Intorment's Neme/Reletionsh	RSII			1 dy	18. Mother's Nemi	e (First, Middle, I	Vaiden Sumeme)
20e 20e 21. 21. 23a Physician /Medical Imm	9e. Intorment's Neme/Reletionsh	seph Maddox						an Rose Sn	
Physician /Medical discount di	Mr. John McGo	· · · · · · · · · · · · · · · · · · ·	1	9b. Mailing Addr	ress (Street e	end Number or Run	al Route Number	City or Town, S	itete, Zip Code)
Physician /Medical discount di	IVII. JUITI IVICUE	ehan Son-ir	n-law	5353	3 Chase	Lions Way Co	olumbia, Ma	aryland 2104	14
23a Physician /Medical Imm	De. Method of Disposition 1 Burial 2 Cremetion 4 Donetton 5 Other (Sp	3 □Removel from Stete	ceme	of Disposition (intery, cremetory ounty Crem	or other plec	ervices, Inc. 0			city or Town, State esville, Marylar
Physician /Medical Imm	1. Signature of Funeral Service L	1 11	M0120		e end Addres Slack 3871	ss of Fecility Funeral Hom Old Columbia	ne, P.A. a Pike Ellico	tt City, MD 2	21043
e sta in resi	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury at initiated events soutting in death) Last	. Poor	OV of Due to (or es	e consequence consequence consequence consequence	land	pregent 105.	fur	retion	Mar
death cer ad for use bed for use		d							
ires that the death certification of the strending of be detached for use and by Physician/Med by Physician/Med	ert II. Other significant condition	na contributing to death bu	ut not resulting	g in the underlyin	ng ceuse give	en in Pert I.			ribute to the cause of 3 Probably 4 T
shoul							24e. Wes e perform		24b. Were eutopsy to evailable prior to completion of confident?
The law page 2							1 🗆 Y	es 2 1 Ho	1 □ Yes 2 🕏
reconficate has director, page	5. Was case reterred to medical examiner?					26. Place of Deat	h (Check only or	18)	
£ 5 m	1 Yes 2 No Nanne of Death Natural 5 Pending		ry 28t	Outpatient 3 o. Time of Injury	28c. Injun	4 LI Nursing Ho	me 5 Reside 28d. Describe ho		
To the Hospital or Attending P within 24 hours ster death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homloide determine	ot be 290 Place of Inju	ury - At home, c. (Specify)				28f. Location (Si City or Town		r or Rural Route Num
Hosp 14 hours 15 all Cal	9a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of examiner: On the basis of and menner ste	examinetion	ige, death occurr and/or investige	red at the tim tion, in my o	ne, date and plece, pinion, deeth occur	end due to the c red et the time, d	ause(s) and man ete and place, ar	ner as stated. nd due to the ceuse(s
To the complete compl	9b. Signeture and title of certifier	1 1			29c. Licenso	e number	2	9d. Date signed	(Month, Day, Year)
30.). Name and address of person v	who completed cause of di	eeth (Item 23s	a) (Type, Print)	DS	15 75	2.	JAnna	ry 19, 20
State 31.	Value Pubo	12 980/ 32. Abdistre	Ola	Au	1111	alle de	1 81.	1 cutt	Cel. Mi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 11:45 AM 16 2000 Jan 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Ellicott City 3232 Normandy Woods Drive, Apt. A | Months Days Hours Min. | 8. Date of Birth (Month, Pey August 10, 1925 Birthplace (State or Foreign Country) Korea 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Days 10 M 2□ F 74 Yrs. "NA" Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 Korea 3232 Normandy Woods Drive: Apt A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Reca - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. Asian 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Furniture Business Elementary/Secondery (0-12) College (1-4or 5+) Businessman un kinowa 18. Mother's Name (First, Middle, Maiden Sumerne) 17. Father's Name (First, Middle, Last) Byoung Lee Hwana Kum Sun 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3232 Normandy Woods Drive: Apt A Ellicott City, Maryland 21043 Rev. Joung Kah Hyun Son in law 20b. Place of Disposition (Name of cemetery, cremetory or other place) Meadowridge Memorial Park, Inc. 01/20/2000 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Licansee. 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervei Between Onset and Deeth therosderotic Cardiovascular Disease Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequença of): Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy 1 Yes 2 No 1 Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident

that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, as 950 ed by the a signed t certificate has b lirector, page 2 s or Attending Physician: director, this funeral After 24 hours after death.

Physician

/Medical

Directo

Funeral

þ

Completed

Be

2

Physician/Medical Examiner

by

Completed

Be

Certification: To

edical

filled in by

Hospital

within 2 94

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at

Demit. Pages 1 and 2 should be filed within 72 hours after 2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or item any Injury or other traumatic event, the Modical Evantine

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

death

25. Wes cese referred to medical examiner? 1 X Yes 2 No 27. Manner of Death

investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a, Certifie (Check only one)

3 ☐ Sulcide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year)

29c. License number

290. Signature and title of certifie

Hemlock Cone Way

on 17,2000

30. Name and address of person who completed dause of deeth (Item 23a) (Type, Print)

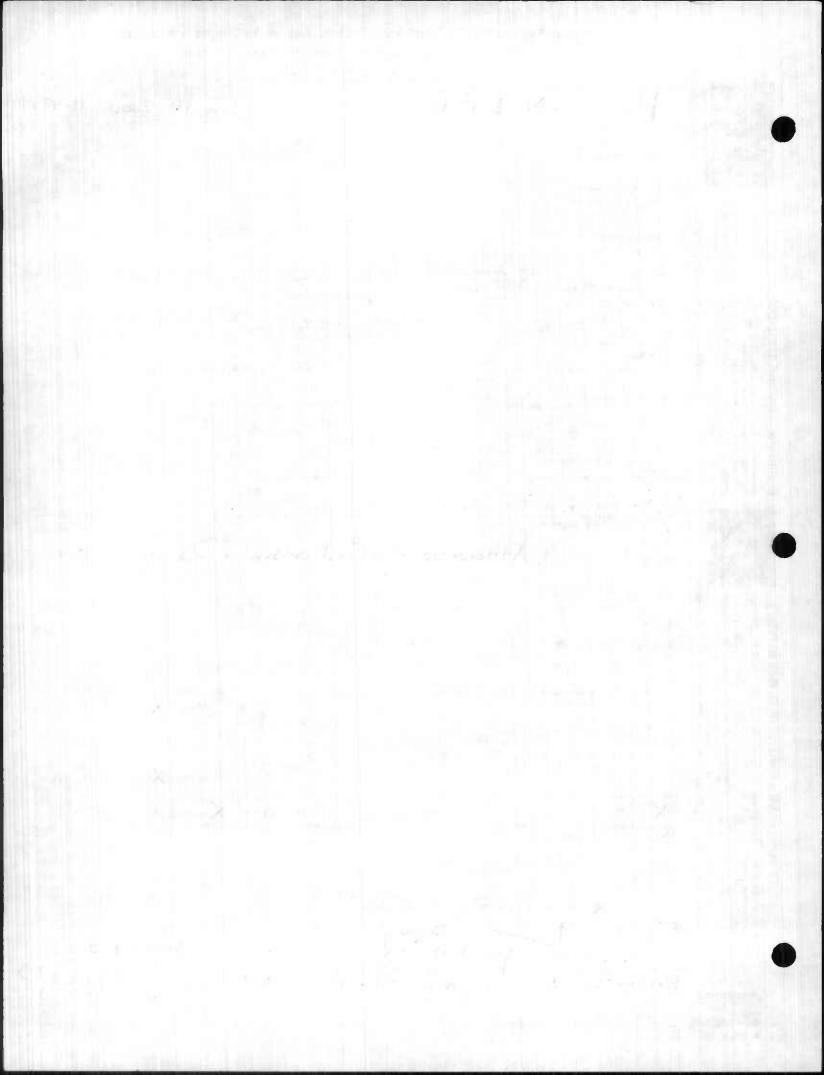
PATRYCE 4565 OYE, MO

State Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Louise Elizabeth Leto January 15, 2000 2:00 A.M. /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 24 Hrs. Hours | Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 250 F Director 216-10-2252 July 3, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-t show I notified at show 1 Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berra 23s or 144 Maryland Ave 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: å 3 Widowed 4 Divorced "natural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) Cotiege (1-4or 5+) 11 Bookkeeper N/A A.A.A. Auto Club 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Is marked of Be Pages 1 and 2 should be To John Schmidt Mazie 0. Winstead 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important of Import 144 Maryland Ave Pasadena, Maryland 21122

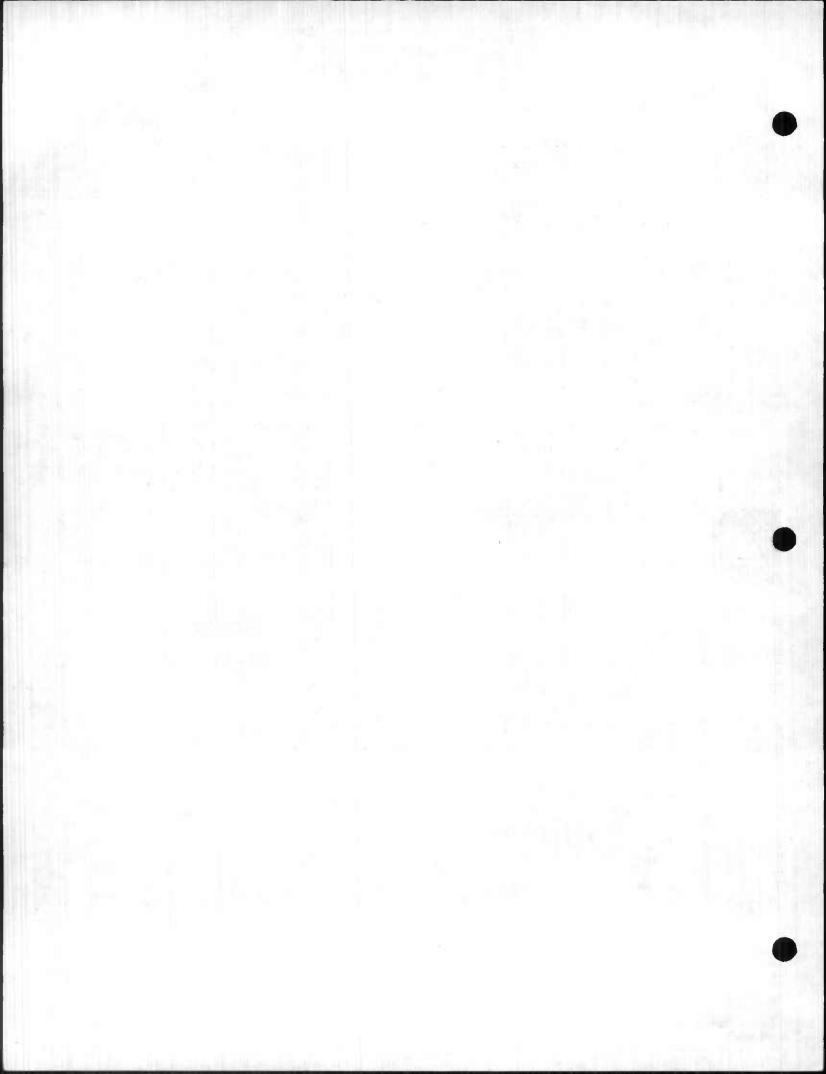
20b. Place of Disposition (Name of cametery, crematory or other place)

Date

20c. Location - City or Town Virginia Endley (Daughter) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 1/18/00 | Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examine Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 1 No 2 No Division of Vital To the Hospital or Attending Physiolan: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was casa referred to medicat axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

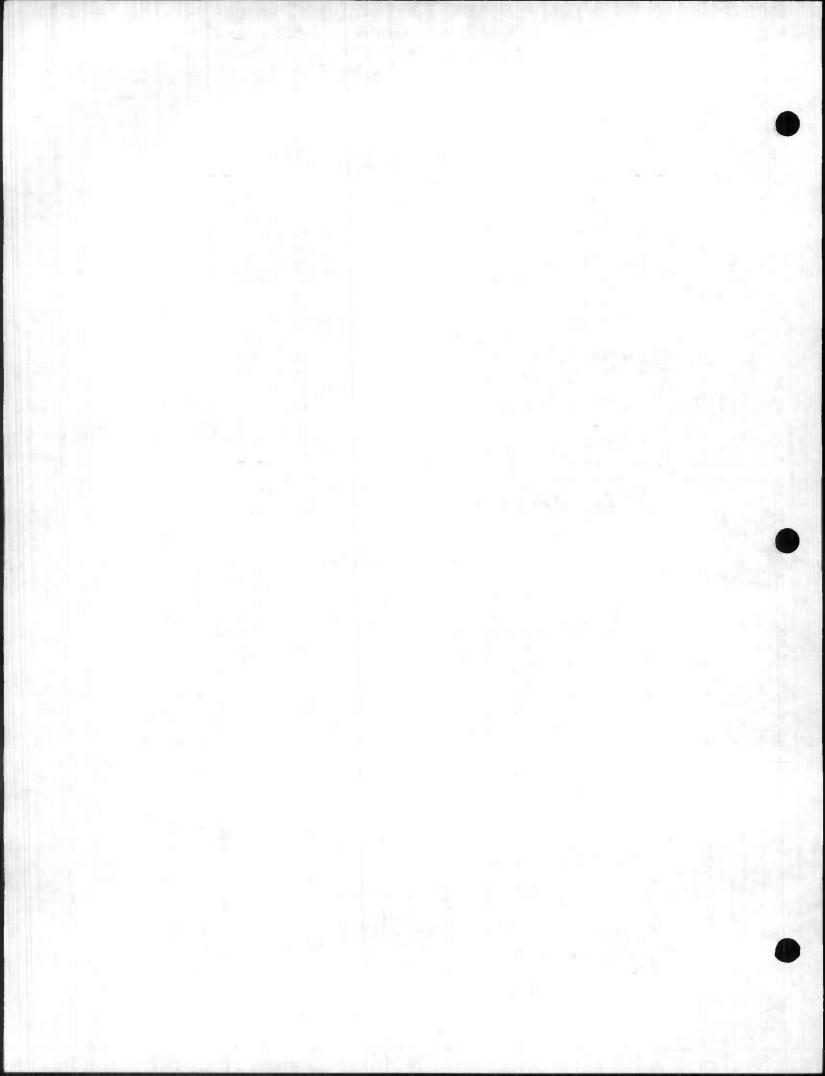
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certiful 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (them 23a) (Type, Print) Rd. 4304 m7N. 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JAN 2000 Registrar



00-0284-005

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

DSES AXAM		Otate of Ivialyia		ent of Health and ate of Death		eg. No.	01284
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) As Facility Name (If not institution, give:		gstone Ma	X am 4b. City, Town, c	2. Date of Dear Month JANUARY or Location of Deeth	Dey	
Funeral Director	203 CARAWAY ROAD 5. Social Security Number 6. Sep. 054-86-4251 Usuel Residence of Decedent	M 2□F 7. Age (In yn	s. last birthday) If Ur Yrs. Monl	REISTER der 1 Yeer If Under 24 H hs Deys Hours Mi	rs. 8. Date of Birth	Year)	MORE 9. Birthplaca (State or Foreign Country) Jamaica
or 28a-f show be notified at Director	10a. Slete 10b. County Md Balto		city, Town or Location				10d. Inside City Limi
ner ceeth with the Marya internet 23s or 28s-1 sho siner must be notified at Funeral Director		12. Was Decedent Ever in Armed Forces?	U.S. 13. Wes De	Zip Code 21136 cedent of Hispanic Origin? specify Cuban, Mexican, Pur	(Specify Yes or No-		/hat Country? - American Indien, k, White, etc.
by E.	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	1 🗌 Yes 2 🖾 No If Yes, Give Year or Detes:	16a, Decedent's L	s 2 No Specify:		Specify.	
be fled within 72 ho tal Hydens. d other than "natur event, the Medical Be Completed	(Specify only highest grade Elementery/Secondery (0-12) 12th grade	Completed) College (1-4or 5+)	(Give kind of life. DO NO	work done during most of w Tuse retired) Specialist	vorking	М. В.	N. A. Bank
od Mental H merked oth metic even	17. Father's Neme (First, Middle, Last) Eric Maxam 19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Add	18. Mother's N Daisey ess (Street and Number or			
of Health and Italian Italian 27 is cother traus	Joan Maxam - Wife	206.		31st Street	Queens,	New Yo	
aparment popularity of the total of t	1XXBurial 2 □ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service License			Memorial and Address of Facility rch F/H We	1-22-2000 \$8	avana 1 amar	r, Jamaica
Physician /Medical Examiner	23a. Part. Enter the disease, or complished, or heert failure. List only or Immediate Cause (Final disease or condition resulting in death)	e ceuse on each line.	ath. Do not enter the r	node of dying, such as card	iac or respiretory err	est,	Approximate thierval Between Onset and Death
e attending physician and bd for use as the burial-transit is ician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last		(or as e consequence				
9 % 00	Pert II. Other significant conditions con	tributing to death but not re	esulting in the underlying	ng cause given in Pert t.	23b. Dld to	1	ntributa to the cause of dea
should should					24a, Was e		24b. Were autopsy finding available prior to completion of cause of death?
certificate has b rector, page 2 s	25. Was case referred to medical			26. Place of D	1 Y		1 Yes 2□ No
를 는 다	examiner? 1 TXYes 2 No 27. Manner of Death 1 XNatural 5 Pending	ospilal: 1 Inpatient 2 28e. Dete of Injury (Month, Day Year)	ER/Outpatient 3D 28b. Time of Injury	DOA Other: 4 Nursing 28c. Injury at Work?	Home 5 X Resid	ence 8 🗆 Oth	
the the	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Pleca of tnjury - At building, etc. (Spec	home, ferm, street, fac city)	1 ☐ Yes 2 ☐ No etory, offica	28f. Location (S City or Tow		er or Rural Route Number,
Funer Funer Icai	(Check only one) 2 Medical Examir			red at the time, date end plation, in my opinion, death or	courred at the time, d	late and place,	and due to the cause(s)
within 2 To the comple	29b. Signeture end title of certifier	1H		29c. License number O.C.M.E.			18,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year RICHARD F. MAYER 5:10 Pm JAN 15 2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 140WARD If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1MM 2□ F 69 Yrs. July 1, 1930 Ohio 297-24-4815 **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 6189 Commodore Ct. U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 25 Merried 1947 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 1948 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Railroad Elementery/Secondary (0-12) College (1-4or 5+) Financial Planner 3 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Leopold Mayer Bertha Klokotsch 19a. intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6189 Commodore Ct. Columbia, Maryland 21045 Mrs. Eleanor E. Mayer Spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 (Cremetion 3 Removel from Stele 4 Donation 5 Other (Specify) All County Cremation Services, Inc. 01/19/2000 Sykesville, Maryland 21 Signature of Funeral Service Licenses 22. Name end Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 110053 x 23e Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate tnterval Between Onset and Deeth Immediate Cause (Finel URCAM) 2 DAYS MULTIPLO SYSTOM disease or condition resulting in deeth) Due to (or es a consequence of): 20445 530515 OVERWHEIMING Due to (or es a consequence of): MEREK PANCYWITTA Due to (or es a consequence of) Pert it. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown HOOKKINS LYNPHOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Nowan INSUFFICIONER 1 ☐ Yes 2 ☐No 1 Yes 2 No

Physician /Medical Examiner

the

980

signed by the a

certificate

this

After

24 hours after death.

within 2 \$

funeral director.

filled in by

venpletely

The law requires that the death certificate be asscuted

Box 68760,

P.O.

Records,

of Vital

Division

or Attending Physician:

Hospital

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

10s. Stete

Director

Funeral

A

Completed

Be

Funeral

Director

28a-f

8 238

8

Hygiene.

and Mental by Y le man

nt of Health a if Itsm 27 is or other tra

Department of Emperature of Em

Pages 1 and 2 should be nent of Health and Mental

72 hours after

21215-0020

Baltimore, Maryland

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

25. Wes case referred to medical examiner?

6 Could not be determined

DAVID O. NYANJOM MO

26. Place of Deeth (Check only one) Hospitet: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of

1 Yes 2 No 27. Menner of Death 1 Netural 2 Accident 5 Pending

28a. Dete of Injury (Month, Day Year) investigation

28c. Injury at Work? 1 Yes 2 No 28e. Place of injury - At home, term, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

PATIO XBNT PARKUMAN

21044

29e. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

CounziA

29b. Signeture end title of certifier

29c. License number D 369 74

LITTLE

29d. Dete signed (Month, Day, Year) OPM 15 2000

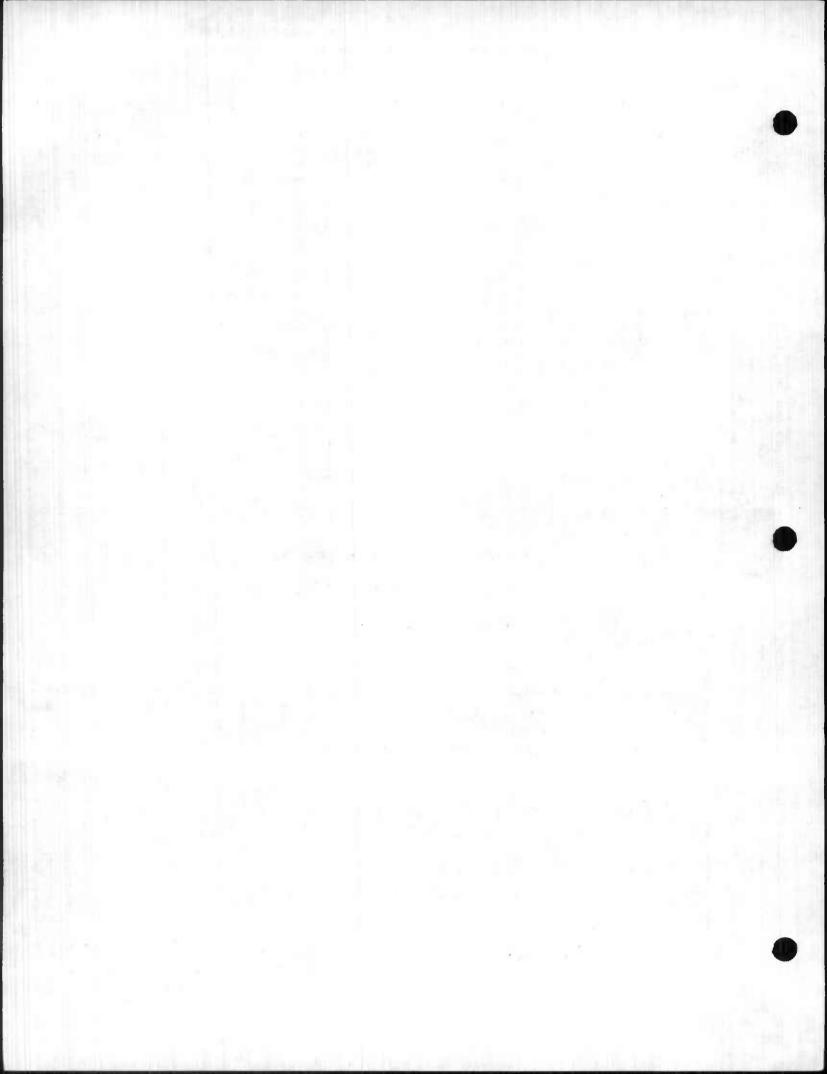
State

Registrar

31. Date tiled (Month, Day, Year)

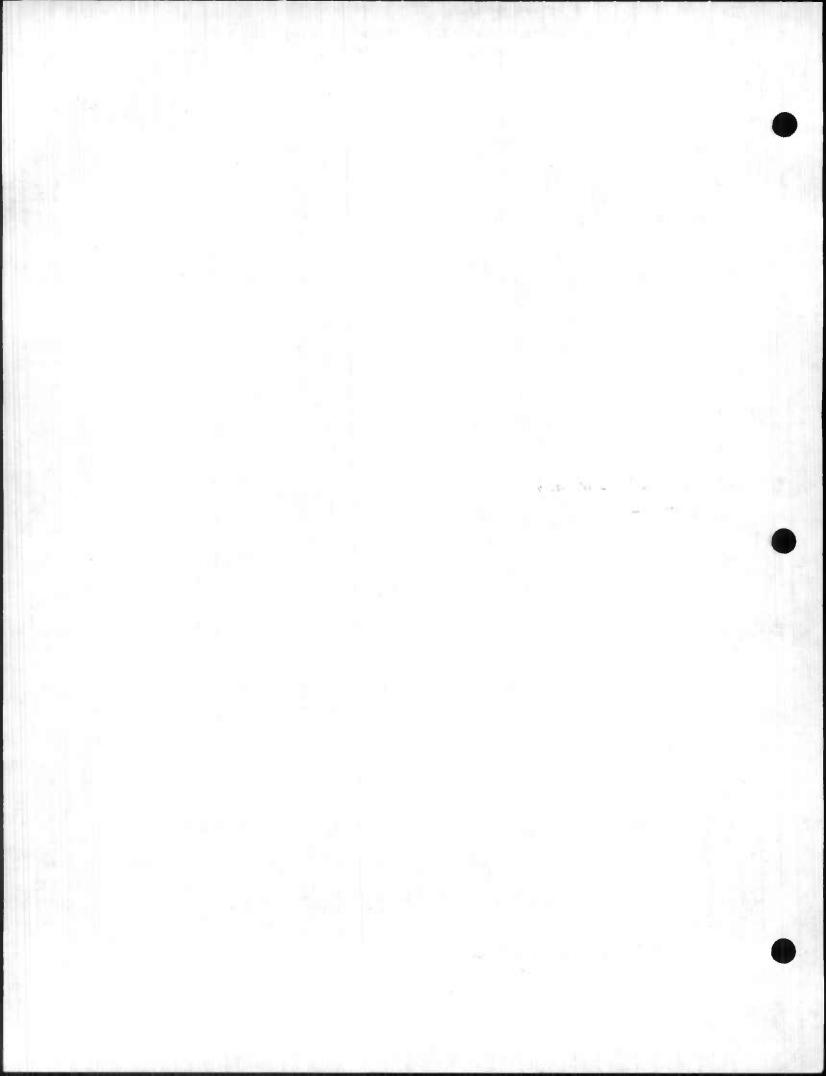
32: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 7 24



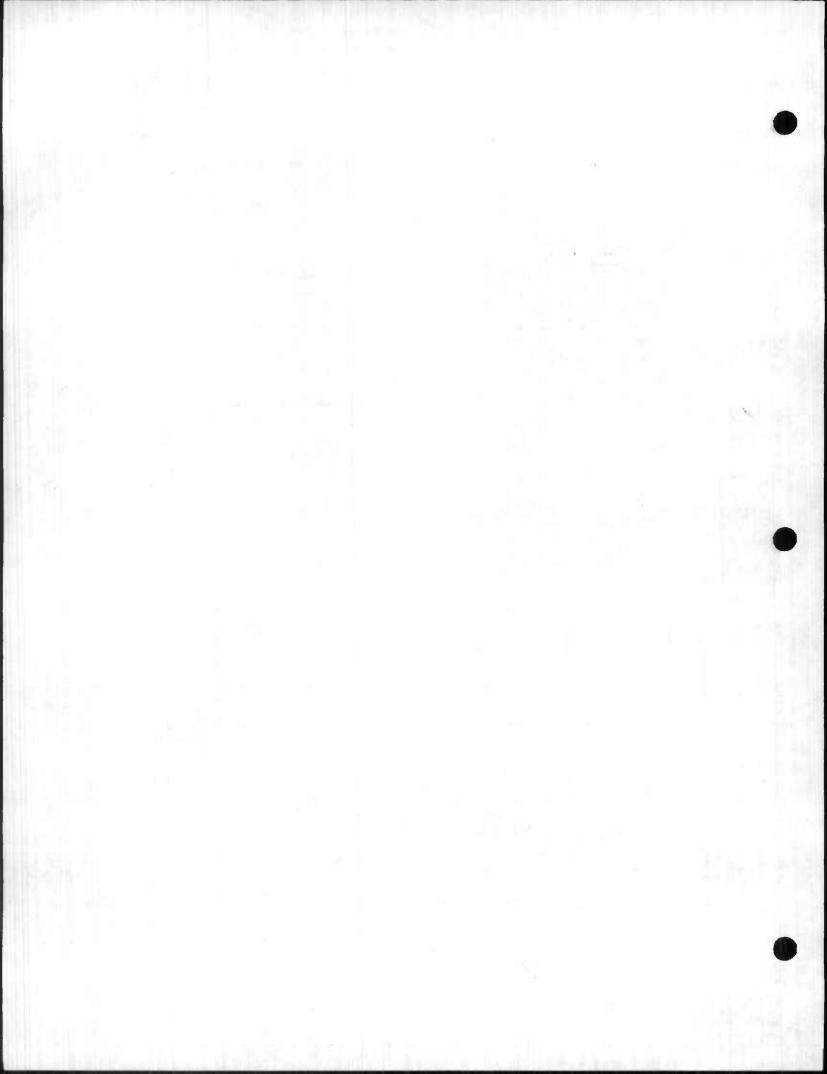
State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 8 6

December 1 Dec				Cer	tificate of	Death	Re	g. No.	01200
Experience Francis Moore Security Steel In America Hospitale at Nercy Medical Ctr. Security There is a fact the state of		1. Decedent's Name (First, Middle, Last)					2. Dete of Deeth		3. Time of Death
Examinities for feathy-thermolecular (final statistics) goes are more and number? Function Function Secule Security Numbers 0.5 secules		Eugene Franc	is Moore						6:55 am
Source Source Processing Processing The Courte Source Processing Processing The Courte Source Processing Processing The Courte Source Processing The Courte Pr					Page 1			4c. County of De	eeth
Use of the second of the sec					Ctr.				
10. State 10. County 10. Coty, Town or Location 10. Line 10. State 10. County 10. Coty 10. State		213-36-3703	144 000 5				(Month, Day,	25, 1937	Country) Maryland
Content Cont	tand and		10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
Content Cont	Mary	MD	Ba	altimor	e				1 □XYes 2 □ No
Content Cont	r 284	10e. Street and Number			10f. Zip Code	i .	10	-	Country?
Content Cont	th with	1316 Morling Aven	ue		2123	11		USA	
Content Cont	urs after dea inf, or flams transfer ma	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give				pecify Yas or No- o Rican, etc.)	Black, W	hite, etc.
Content Cont	2 hor	15. Decedent's Edu	cation	16a. Deced	lent's Usuel Occ	upation	1	6b. Kind of Busine	
Norman D. Moore Norman D. Moore	hin 7	(Specify only highest grade		life. L	kind of work don DO NOT use retii	e during most of wor red)	rking		
Norman D. Moore Norman D. Moore	od with	10		Flora	1 Arran			1101100	
Norman D. Moore 19. Making Address (Street and Number or Plant Part) 20. Making Address (Street and Number or Plant Part) 21. Making Address (Street Part) 22. Making Address (Street Part) 23. Making Address (Street Part) 24. Wes en surface or Part) 19. Making Address (Street Part) 24. Wes en surface or Part) 19. Making Address (Street Part) 19. Making Address (Street Part) 24. Wes en surface or Part) 19. Making Address (Street Part) 24. Wes en surface or Part (Street Part) 25. Making Address (Street Part) 26. Making Address (Street Part) 27. Making Address (Street Part) 28. Making Address (Street Part) 29. Making Address (単三 名 ・	17. Father's Neme (First, Middle, Last)							
19s. Informerits Name/Perialcrating (Types, Print) 19s. Main Address Stored and Number of Pour Route Route Route Route (See 20 No. 1) 200. Pleas of Disposition (Name of Company) 200. Pleas of Dispos							-		
206. Method of Disposition 1 and 1 a	and and								e, Zip Code)
Concentrate of the property of the place o						7			or Town State
Physician (Medical Examiner) The proposed of	ment of Itant: If Ita	1 ☐ Buriaf 2 ☒ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	lemoval from Stete	cemetery, cren esapeak	netory or other p	tory inc	1/17/00 B	eltsville	
Post Concept	any in	21. Signature of Funerel Service Licens	the	22	AFA, St 3717 Gre	ephen D. 1 en Pastur	Lohrmann, es Drive,	P.A. Towson,	MD 21286
Sequentially indicated Sequentially indica	Physician	231 Fart Enter the disease, or complete anock, or heert failure. List only or	icetions thet caused the dea ne cause on each line.	th. Do not ente	er the mode of d	ylng, such es cardiec	c or respiratory arre	st,	Interval Between
Coroanry Artery Disease Coroanry Artery Disease 10 yrs		disease or condition				ilure			10 yrs
Due to (or es a consequenca of): Due to (or es a consequenca of): Due to (or es a consequenca of):	E E					ease			10 yrs
d. Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death 1	an and ineltrans	Sequentiatly fist conditions, if any, leeding to immediate cause. Enter Underlying	D						
24a. Wes en autopsy finding available prior to completion of cause of death? 24a. Wes en autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death? 1 yes 2 No	5 00	resulting in death) Last		or es a conseq	uenca of):				
24a. Wes en autopsy finding available prior to completion of cause of death? 24a. Wes en autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death? 1 yes 2 No	tendi or use		3						
24a. Wes en autopsy finding available prior to completion of cause of death? 24a. Wes en autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death? 1 yes 2 No	the at red for red for	Pert it, Other significant conditions con	ntributing to death but not re-	sulting in the u	nderlying cause	given in Part I.	23b. Did tol	bacco use contrib	uts to the cause of death
25. Was case referred to medical examiner? 26. Piece of Death (Check only one) 27. Menner of Death 1							1)\(\int \) Ys	8 2 No 3	Probably 4 Unknow
25. Was case referred to medical examiner: 25. Was case referred to medical examiner: 1	> 100 =								available prior to completion of cause
25. Was case referred to medical examiner: 25. Was case referred to medical examiner: 1	The I						1□ Ye	s 2 No	1 □ Yes 2 □ No
Section 1 Meatural 2 Accident 3 Sulcide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, offica 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 29a. Certifier (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the causa(s) and manner as stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	yaician: is certifica director,	25. Was case referred to medical examiner?	fospital: 1 ☐ Inpatient 2 ☐	ER/Outpetien	t 3 DOA	ther:		nce 6 Other (S	lla Maris @
29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (ftem 23a) (Type, Print) J. O Mahony, MD 301 St Paul, Suite 907, Baltimore, MD 21202	ath. r: After the funeral	1 ☐ Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)				28d. Describe ho	w Injury occurred	
29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (ftem 23a) (Type, Print) J. O Mahony, MD 301 St Paul, Suite 907, Baltimore, MD 21202	rs after de at Directo led in by th	determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, fectory, offic	a	28f. Location (Str City or Town	eet and Number of State)	r Rurel Route Number,
D46389 January 16, 2000 30. Neme and address of person who completed cause of death (flem 23a) (Type, Print) J. O Mahony, MD 301 St Paul, Suite 907, Baltimore, MD 21202	n 24 hou n 24 hou ne Funer pietely fil	(Check only 2 Medical Exam)	ner: On the basis of examin	owledge, deeth ation and/or inv	occurred at the vestigetion, in my	time, dete and place opinton, deeth occu	a, and due to the ca urred at the time, de	usa(s) and manne ite end placa, and	r as stated. due to the cause(s)
D46389 January 16, 2000 30. Neme and address of person who completed cause of death (flem 23a) (Type, Print) J. O Mahony, MD 301 St Paul, Suite 907, Baltimore, MD 21202	To the Comp		400		29c. Lice	nse number	29	d. Date signed (M	lonth, Day, Year)
J. O Mahony, MD 301 St Paul, Suite 907, Baltimore, MD 21202		10111	11 15	m 23a) /Tune		46389		January 1	.6, 2000
21 Data Blad Algorith Day York	13					Baltimore.	MD 2120)2	
	State								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, La	et)	Cel	rtificate of	Dealli	2. Date of Dea	leg. No.	3. Time of Death
Physician /Medical	NETTIE		MOS	SCOE		Month	B, 2000 Yea	
Examiner	4a Facility Name (If not institution, giv MILFORD MANOR NU				4b. City, Town, or Lo BALTIMORE	cation of Death	4c. County of De BALTIMOR	
Funeral Director	215-30-3307A	D	n yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day APR . 1]	, Year) 9. B	tirthplace (State or Fore Country)
with the Maryland a or 28e-f show Libe notified at Director	Usual Residence of Decedent 10a. State 10b. County MD N/		c. City, Town or Lo					10d. Inside City Limit
s or 28e-f show be notified at Director	10e. Street and Number		DAGII	10f. Zip Code		1	log. Citizen of What (
23a o untbe	3601 FORDS LANE	#821			21215	200	U.S.A.	
natural, or tame 23 dical Examiner must sted by Funeral	11, Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1 No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rece - Ar Black, Wi Specify:	nerican Indian, nite, atc. WHITE
ygiene. Ar the Medical E Completed	15. Decedent's Education of Specify only highest grade Elementary/Secondary (0-12)	ducation	16a. Deced (Give life.	lent's Usual Occup kind of work done DO NOT use retire	pation during most of worki d)	ing	16b. Kind of Busines	
	17. Father's Name (First, Middle, Last,		HOMEM	AKER	18. Mother's Name		OWN HOME	
o Bental	SAM		SI	MON	ANNA	(First, Milotie, I		SELIGMAN
Mand M Surran	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numbe	r, City or Town, State	
n 27 l	CAROLYN SMITH /				COURT - BA		, MD 2120	
ment of H ant: if he jury or of	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Dispo cemetery, crer ARLINGTO	natory or other pla		/19/00	20c. Location - City of BALTIMOR	
Import any in	21. Signature of Funeral Service Licer	1500		2. Name and Address			INSON & B	ROS., INC., MD 21208
nysician Medical xaminer	23a. Part1. Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a		OPD				Interval Between Onset and Death
nding physician and use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a conseq					
d by the attending stached for use.	Part II. Other significant conditions o	ontributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23b. Did to	obacco use contribu	its to the cause of de
						1 🗆 Y	'ss 2□No 3□	Probably 45 Unkr
oned by the attending posterior as as deteched for use as by Physician/Mer								
5.8						24e. Wes e		b. Were autopsy tindin- available prior to
se 2 should be						perfor	med?	b. Were autopsy finding available prior to completion of cause
hes been sign ge 2 should be impleted by	25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death	28a. Date of Injury	2□ ER/Outpetier 28b. Time of	I 3LI DOA		perfor	med? (es 2 1 No ne) ence 8 0 Other (S)	D. Were autopsy finding available prior to complete of cause of death? 1 Yes 2 No
hes been sign ge 2 should be impleted by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye) 28e. Place of Injury	ar) 28b. Time of Injury At home, farm, str	28c. Inju Wo	ner: 4 Nursing Horry et rk? Yes 2 No	perfor 1 Y 1 (Check only or me 5 Resid 28d. Describe h	ies 25 No ne) ence 8 Other (S) ow injury occurred	D. Were autopsy tindin available prior to complete of cause of death? 1 Yes 2 No
ge 2 should be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S)	At home, farm, str	28c. Inju Wo M I Deet, factory, office	ner: 4 Nursing Hory et no. 1 N	perfor 1 Yen (Check only or The Sign Resid 28d. Describe h 28f. Location (S City or Tow and due to the c	es 2 No ne) ence 8 Other (S) ow injury occurred treet and Number or n, State) ause(s) and manner	b. Were autopsy tindin available prior to completion of cause of death? 1 Yes 2 No Decity) Rural Route Number,
thes been signing 2 should be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day Ye 28e. Place of Injury - building, etc. (S	At home, farm, str	28c. Inju 28c. Inju Wo 1 eet, factory, office	ner. 4 Nursing Horny et rk? Yes 2 No	perfor 1 Y 1 Check only or The S Resid 28d. Describe h 28f. Location (S City or Tow and due to the cell at the time, cell	es 2 No ne) ence 8 Other (S) ow injury occurred treet and Number or n, State) ause(s) and manner late and plece, and d	b. Were autopsy tinding available prior to completion of cause of death? 1 Yes 2 No Decity) Rural Route Number, es stated. ue to tha cause(s)
is after death. I Director: After this certificate has been sign at Director. After the funeral director, page 2 should be certification: To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Ya 28e. Place of Injury - building, etc. (S) yelclan: To the best of my niner: On the basis of exa	At home, farm, str	28c. Inju 28c. Inju Wo 1 eet, factory, office	ner. 4 Nursing Horny et rk? Yes 2 No	perfor 1 Y 1 Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the ced at the time, ced	es 2 No ne) ence 8 Other (Si ow injury occurred treet and Number or n, State) ause(s) and manner late and place, and d	b. Were autopsy tinding available prior to completion of cause of death? 1 Yes 2 No Decity) Rural Route Number, es stated. ue to tha cause(s)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 15, 2000 ARMIN MOHR 11:04 PM F. /Medical 4e Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4232 FALLSTAFF ROAD BALTIMORE N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funeral** Deys Months Hours XXM 2DF 108-18-7486 8/13/25 NÝ Director Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show Yes 2□No Director 28a-f MD N/A BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 21215 USA 4232 FALLSTAFF ROAD 238 Funeral 12. Was Deceden! Ever in U,S.
Armed Forcas II

NOVas 2 IV II
ff Vas, Giva
Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Hygiens, ther then "natural", or flan ent, the Medical Examiner Black, Whita, etc. filed within 72 hours after 1 Nevar Married Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify:WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER **ENGINEERING** 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Name (First Middle Last) Pages 1 and 2 should be farment of Health and Mental H lant: If Item 27 is marked oth lary or other traumatic even Be **MOHR** JOSEPHINE (UNKNOWN) ALEX 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Neme/Ralationship (Type, Print) LUCILLE MOHR/ WIFE 4232 FALLSTAFF ROAD BALTIMORE, MD. 21215 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Department of Important if Important if Important if Important if Important if Important if Important in Impo 1 Burial 2 Cramation 3 Removal from Stata VETERANS CEMETERY 1/19/2000 GARRISON, MD. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ocen C 23a. Part1. Enter the disasse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Chronic lymphocytic leukemia /Medical Immediata Causa (Final 8 years disassa or condition resulting in death) Examiner Examiner The law requires that the death certificate be asscuted Sequentielly list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initieted events rasulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of) 980 signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to should completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: funeral director, Be 25. Was casa ralarred to medical axaminar? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Dalvatural 2 Accidant 5 Panding 1 Yes 2 No 24 hours after death.

Funeral Director: A investigation 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homlcida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifiar completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 eda 29b. Signatura and litla of certifian 29c. License number 29d. Date signed (Month, Day, Year) 18,2000 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Ian W. Flim, m.D. Nocth Wolfe St. Baltimore

DHMH 16 Rev 6/95

State

Registrar

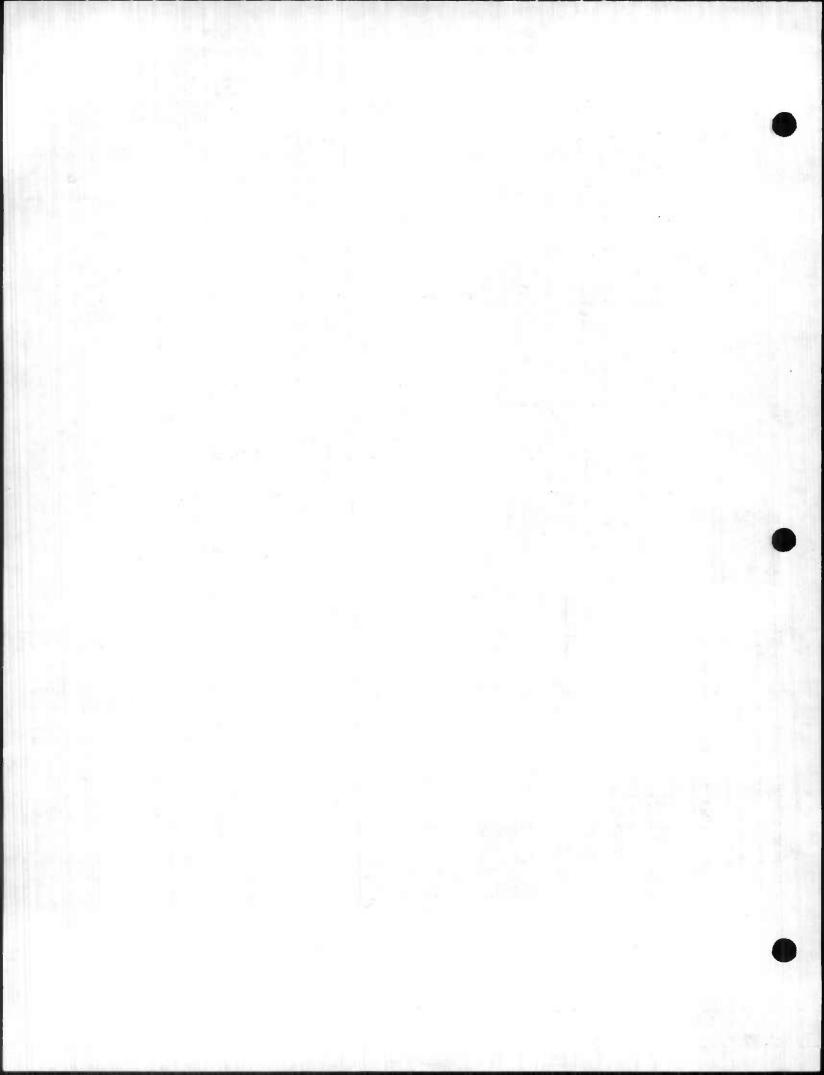
31. Data liled (Month, Day, Year)

JAN 2 0

2000

32. Registrar's Signatura

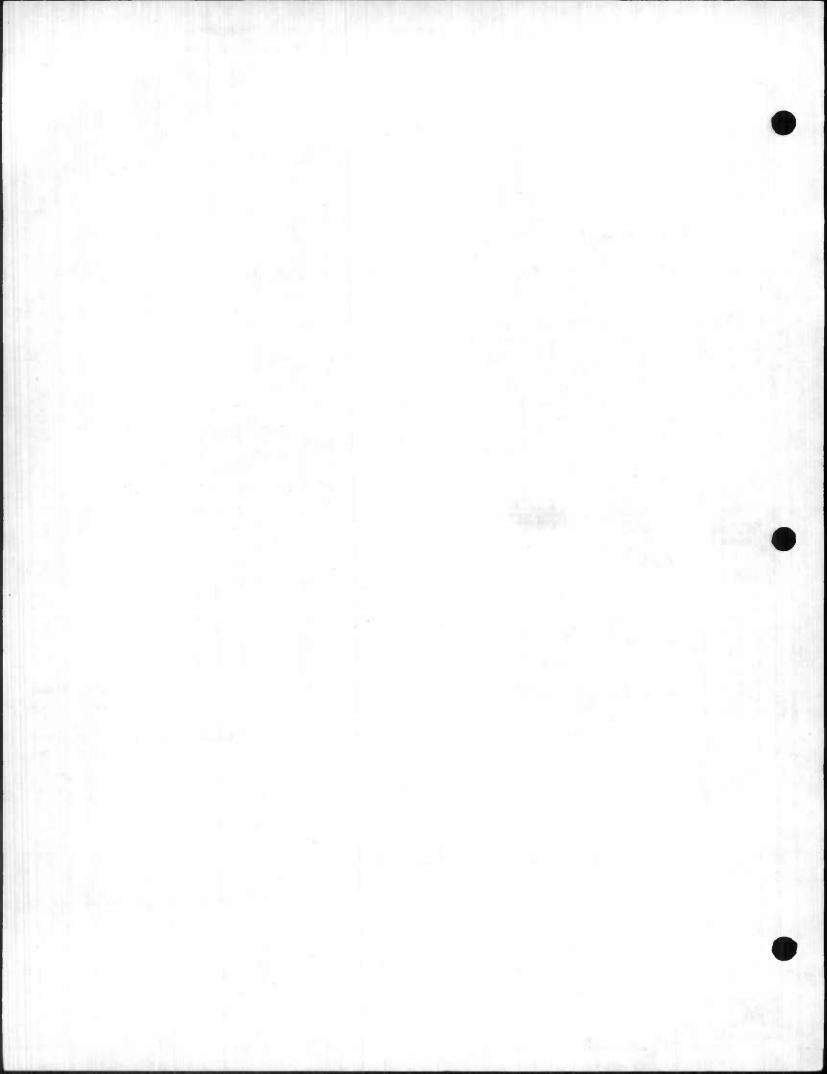
Gener



State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Re	g, No.	01209
hysician	1. Decedent's Nama (First, Middla, Last) RICHARD MOLLOY	2. Data of Death Month	Day \	3. Time of Death
dical		JANUAR		000 01:05 AM
iner	80.00	IMORE	4c. County of	Death
ral or	5. Social Security Number 214–18–1289 6. Sex 12 M 2 F 7. Aga (In yrs. last birthday) 8. Sex 9. Aga (In yrs. last birthday)	8. Data of Birth (Month, Day, Dec. 04		B. Birthplace (Stata or Foreign Country) Maryland
	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
ò				1 Vas 2 No
Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	at Country?
	100 Harbor View Drive Apt.1507 21230		USA	
by Funeral	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert It. Yes, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes, Giva Yaar or Datas:	pecity Yas or No- lo Rican, etc.)		American Indian, Whita, etc. White
Completed	15. Decedent's Education (Specify only highast grade completed) (Giva kind of work done during most of work life. DO NOT use retired)	rking 1	6b. Kind of Busi	nass/Industry
Idm	Elementery/Secondary (0-12) College (1-4or 5+)		laval Ac	ademy
	12 4 Math Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name	ma (First, Middle, M		
To Be		M. Moler		
F	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		City or Town, Si	tata, Zip Code)
	Robert K. Molloy (Brother) 1113 Rose Lane Virgin	nia Beach	Virgin	ia 23451
	20a. Mathod of Disposition 20b. Place of Disposition (Nama of			ity or Town, Stata
	1 Burial 2 Cramation 3 Hemoval from Stata	unkwn N	orfolk,	Va
	21. Signature of Fynaral Sarvice Licansee Sea 22. Nama and Addrass of Facility			
	McCully-Polyniak	Funeral	Home P.	A.
	23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac shock, or heart feilure. List only one cause on each line.	c or respiretory arre	est, Ma	Approximate Interval Between
n				Onset and Death
	Immediata Causa (Final diseasa or condition LIVER FAILURE			
	resulting in death) Dua to (or as a consequence of):		UIG-1	
Examiner	METASTATIC LIVER DIS	EASE		
Xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	Cause (Disease or injury		LL3-	
Medical	resulting in death) Last Dua to (or as a consequence of):			
Completed by Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tol	bacco usa conti	ributs to the cause of death?
Phy		1 🗆 Ye	98 2□No 3	Probably 42 Unknown
1 by		240 14/00	autoccu T	24b. Wera autopsy tindings
ete		24a. Was ar parform		available prior to completion of cause
du				of death?
	GE Was associated to modical	1 □ Ya		1 ☐ Yas 2 No
o Be	examiner? Hospital: Other:	ath (Check only one		(Enneith)
1: To	27. Mannar of Death 28a. Data of Injury 28b. Tima of 28c. Injury at	toma 5 ☐ Reside		
Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident invastigation M 1 Year 2 No	9190		
HC	3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office			or Rural Routa Number,
Cen	4 ☐ Homicida building, efc. (Specify)	City or Town	, SIBIN)	
edical (29a. Certifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation.			
Z	29b. Signature and title of cartifier 29c. License number			(Month, Day, Year)
	DARKhan, MD RES-00	0 2	ANUAR	1,19,2000
	JOHNS HOPKINS BAYVIEW MEDICAL CENTER,	DEPARTI	MENTO	+ WEDICINE
tate	31. Data filed (Month, Day, Yeâr) 32. Redistrar's Signatura			
gistrar	JAN 2 0 2000 Serene & Spark			

Registrar DHMH 16 Rev 6/95



68760 o ئە Records, Division of Vital

Examiner physician and s the burial-transit death certificate be executed Physician/Medical 98 þ Completed The law Be 10 this After thi To the Hospital or Attending P1 within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera Certification:

Physician

/Medical

Examiner

Directo

Funeral

p

Completed

Be

Funeral

Director

28a-f

b

Norms 23a

'natural', or

filed within 7 Hygiene. other then "n

permit. Pages 1 and 2 ahouid be filled w.
Department of Health and Mantal Hygien.
Emportant: if flam 27 is marked other that Adly fluiny or other traumatic.

Physician

/Medical

Examine

land 21215-0020

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and mennar stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) heeur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEIGHTS AVE

State Registrar

edical

PAINEEM

JAN 2 0 2000

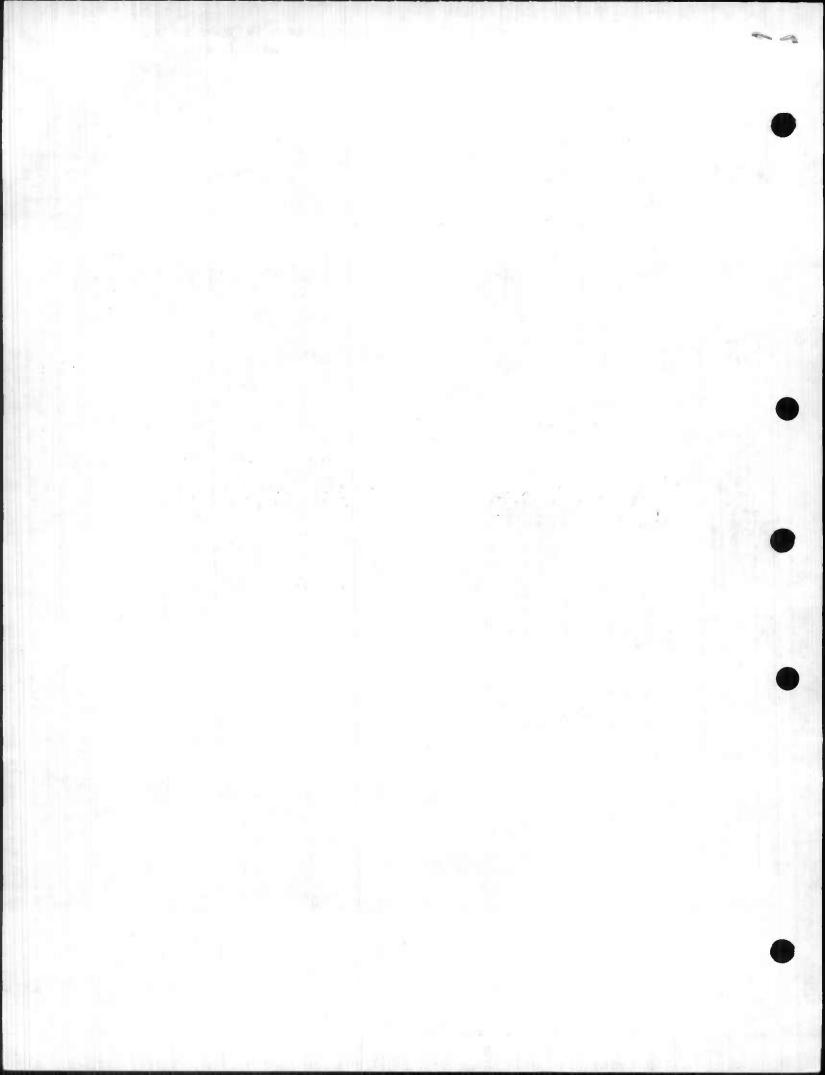
31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

7220

32. Registrar's Signeture

AKHAMI,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15, Marie Jan. Perton 2000 7:08 PM /Medical 4b. City, Town, or Location of Death 4a Fscility Name (If not institution, give street and number) 4c. County of Death Examiner 216 Werner Rd. Baltimore Anne Arundel If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan 3, 1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months 10 M 20 F 219-05-5300 83 Vre Maryland Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Director Anne Arundel Baltimore 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a or 216 Werner Rd. 21226 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedant Ever in U,S Armed Forces? or Nerris filed within 72 hours after 1 Pes 2 No If Yes, Give Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Maic Hotel permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygingortant: if Item 27 is marked other party Injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ebenhack Bertha Laauge 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) (Sister) Edna Holsey 2208 Lake Dr. Pasadena, Md. 21122 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stata 2000 Cedar Hill Cemetery Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral home PA 3111 Mountain Rd. Pasadena Md. enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and physician a P.O. Box 68760, Physician/Medical Due to (or es e consequence of): USB BSU Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detack 1 Yes 2 No 3 Probably Thknown Division of Vital Records. PV 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) 1 Yes No Hospitet: Other: 4 Nursing Home Seriesidence 6 Other (Specify) Medical Certification: To 3 DOA 1 Inpatient 2 ER/Outpetient 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

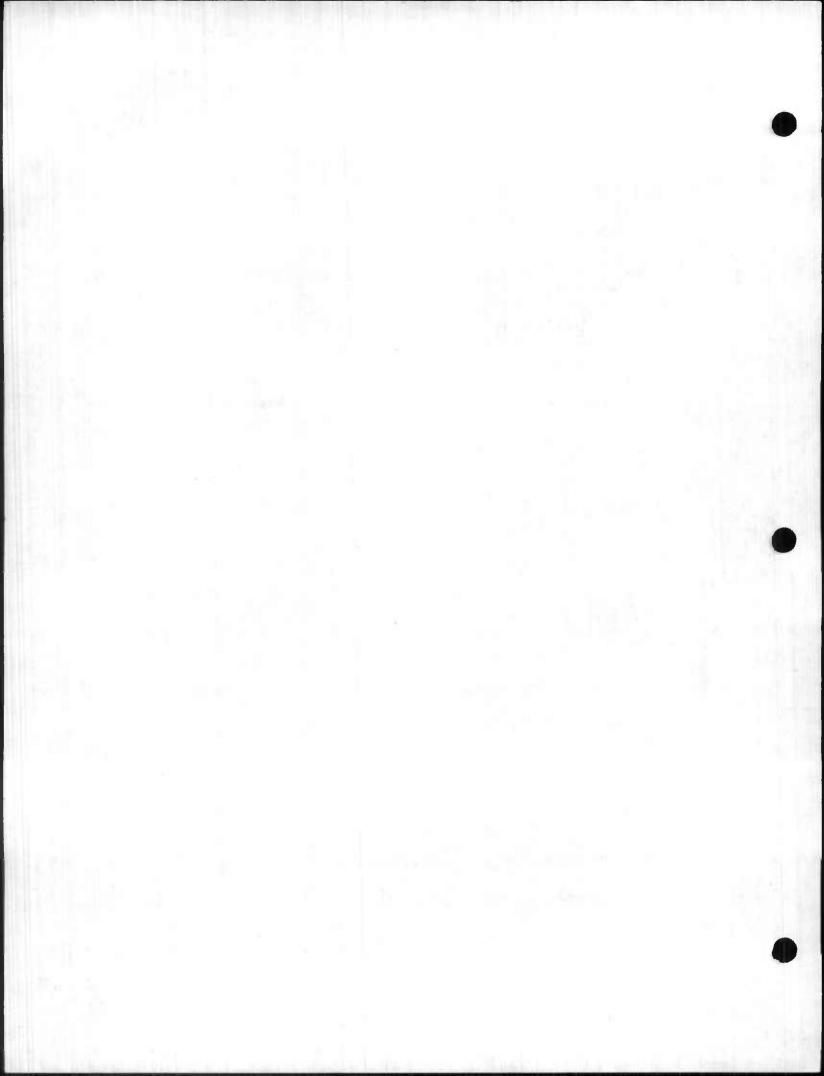
Registrar

WANNE

JAN 20 2000

31. Date filed (Month, Day, Year)

Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month January 4b. City, Town, or Location of Death 2000 4c. County of Death Baltimore Hospital If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day,) Oct. 29 Days 10XM 20 F Months Hours Oct.

1. Decedent's Name (First, Middle, Last) 3. Time of Death RALPH **Physician** 4.45 PM /Medical 4a Facility Name (If not institution, give street and number, Examiner Harpor 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia Funeral Director 215-30-0421 **Uaual Residence of Deceden** 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flama 23s or USA 21226 216 Werner Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int. If them 27 is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) City Government Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delt Unknown Alexander Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Amportant: If Nem 27 Is apy Injury or other treat 216 Werner Road, Baltimore, MD. 21226 Linda K. Perkins(spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1) Bunal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Jan. 19 Middle River, Maryland Holly Hills Cemetery 2000 22. Name and Addresa of Facility 21. Signeture of Funerel Service Licensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 usch 23a. Part1. Enter the disease, or corplications that caused the death ahock, or heer failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Renou The law requires that the death certificete be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. LC 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 Yes 2 No

Be

edical Certification: To

certificate

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

25. Was case referred to medical examiner?

2 Accident

4 I Homlcide

3 Suicide

29a. Certifier

1 Yes 2 No 27. Manner of Death 5 Pending investigation

6 Could not be determined

1 DInpatient 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 10 No

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and menner ateted. (Check only one) 29b. Signature and title of cartifier

29c. License number

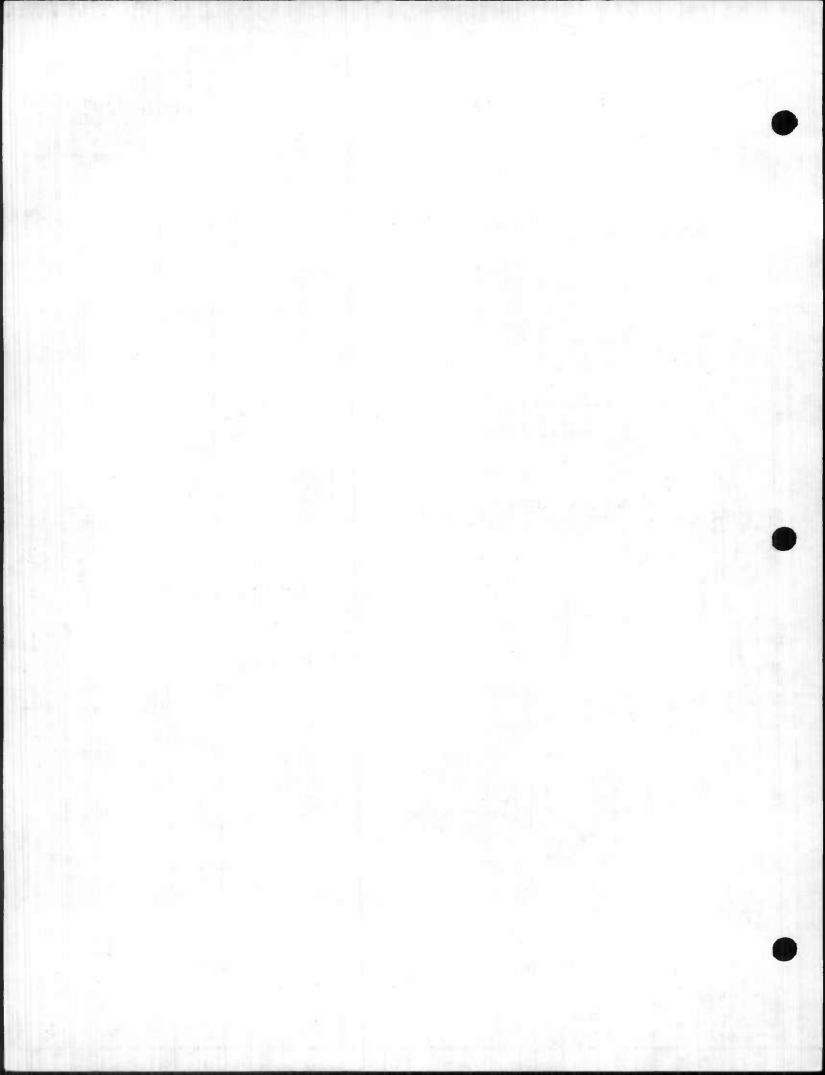
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

3001 South Hanover Street, Baltimore, MD 21225 BakLeh, MD lohanad

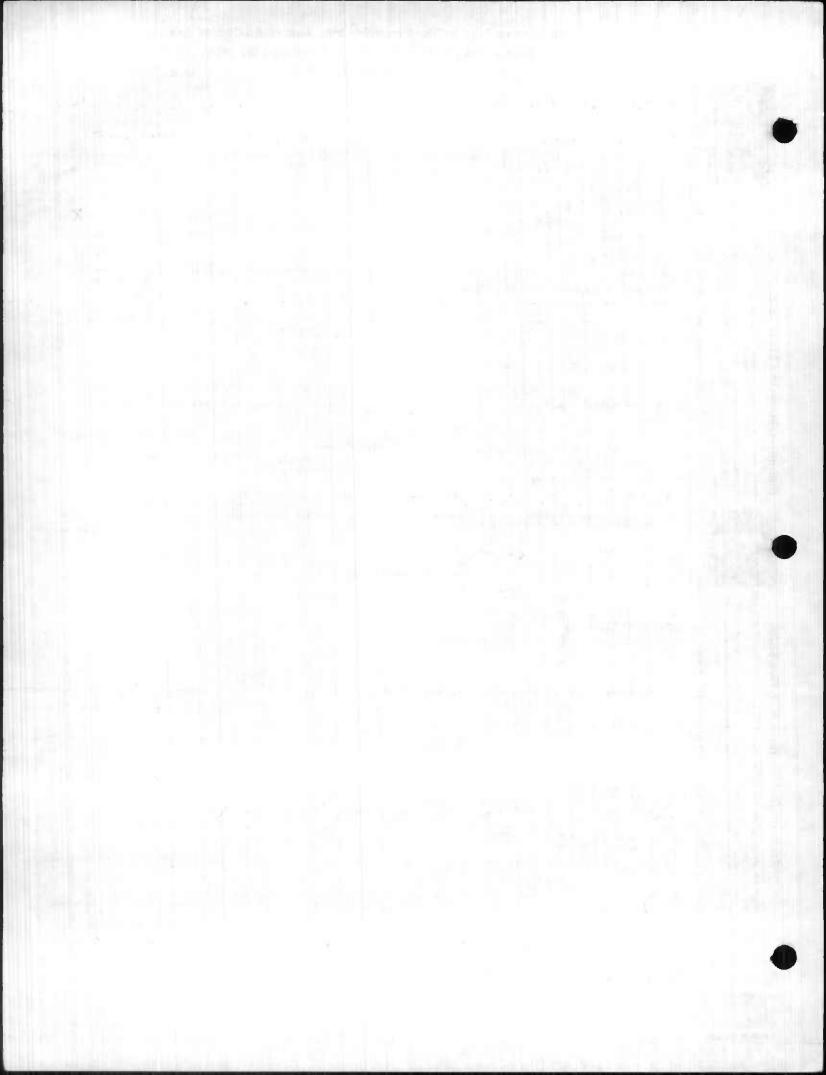
State Registrar 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

sician	1. Decedent's Neme (First, Middle, L. AUAN WINTE		545					2. Data of Date Month	Dey	Year D00	3. Tima of Death
edical iminer	4a Facility Nama (If not institution, gi	a street and number					4b. City, Town, or L		4c. County	of Death	
	8560 2 mel AUDA	4					siculal Si		Mout		
eral tor		Sex 7. A	iga (In yrs.	62 Yr	Months	ar 1 Yaar Days		8. Data of Birt (Month, Day Octobe	r 9, 1937	9. Birthp Coun	laca (Stata or Foraig try) Ohio
	10a. Stata 10b. County		10c. Cit	y, Town o	or Location					1	0d. Insida City Limits
cto	Maryland M	ontgomery					Silver Spring				1 Yas 2 □ No
al Director	10e. Street and Number 8560 2nd Avenue				10f. 2	ip Coda	20910		10g. Citizan of V		try? S.A.
by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forces 1 Yas 2 If If Yas, Giva Yaar or Datas:	No	,S.	13. Was Dec If Yas, sp 1 ☐ Yas		Hispanic Origin? (S pan, Maxicen, Puart Specify:	pecify Yas or No- p Ricen, atc.)	Specify	k, Whita,	en Indian, atc. White
Completed	15. Decedent's E (Specify only highast gr	ducetion ada complatad)		16a. D	ecedent's Us Giva kind of w	ual Occu	pation during most of world)	king	16b. Kind of Bu		
duic	Elamentery/Secondary (0-12)	Collaga (1-4or	5+)	1	ra. DO NOT	usa <i>ranre</i>	Scientist		Chemical Res		I Research
Ü	17. Fathar's Nama (First, Middla, Las			1				Nama (First, Middla, Maidan Sumama)			
other treumatic event, the M	Lowel	Endly Peters					3/14/3	Madeleine Joan Thorndike			ke
-	19a. Informant's Name/Raiationship			19b. N	Aailing Addre	ss (Stree	t and Number or Ru				
	Mrs. Elizabeth Pet	ers Spo	oușe		1361	Rout	e 108 Highlar	nd, Maryland	d 20777		
	20a. Mathod of Disposition		20b. F	Place of D	isposition (N	ama of othar pla	nce)	Data	20c. Location -	City or To	wn, Stata
	1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Space		a A	II Cour	ity Crema	ation S	ervices, Inc.	1/19/2000	Syl	kesville	, Maryland
	21. Signatura of Funeral Sarvice Licensae 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21										
once.	23a. Part1. Enter the disease, or con shock, or heert feilure. List only			, ,		3871	Old Columbi	a Pike Ellic	ott City, MD	21043	Approximate
an is a second and is a second	Immediata Causa (Final disaasa or condition rasulting in daath)	a PHOUR	Due to (o	or es a co	nsequence o	r):					Onset and Deeth
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated evants	Dua to (or es a consequance of): C. Dua to (or as a consequance of):									
-	rasulting in death) Last	d	Dua to (o	as a coi	isequalica of	,.				1	
Cia	Part II. Other significant conditions	contributing to death	but not ras	ultina in t	ha undarivino	ceusa d	ivan in Part I.	23b. Dld 1	lobacco uae co	tribute to	the cause of death
y Phys								10	Yes 2 No	3 Prof	bably 4 Unknow
Completed by Physician/N								24a. Was perfo	an autopsy rmed?	av	ara autopsy findings allable prior to mpletion of cause daath?
E								101	Yes 2000	10	Yas 2000
Be	25. Was casa rafarred to medical exeminar?							ith (Check only o	ona)		
2	1D as 2 No 27. Manner of Death 1 D ature 5 Pending 2 Accidant Invastigatio	28a. Data of Inj (Month, D	28a. Data of Injury (Month, Dey Year)		utpatient 3 DOA Other: 4 Nursing Tima of Injury M 28c. Injury et Work? M 1 Yas 2 No		iry et ork?	g Homa 5 Hesidence 6 □Othar (Specify) 28d. Describe how injury occurred		y)	
edical Certification:	3 Suicida 6 Could not l 4 Homicide detarmined					28f. Location (Street and Number or Rural Roc City or Town, Stata)			il Route Number,		
dical	29a. Certifier 1 Certifying P	nysictan: To the best miner: On the basis and manner s	of axamine	wledge, o	death occurre or invastigetion	d at tha t	ima, data and place opinion, daath occu	, and due to tha rred at tha tima,	causa(s) and ma data and placa,	nnar as s and dua to	tated. the cause(s)
M	29b. Signature and title of certifier		10	1	2	_	sa number		29d. Data signe	d (Month,	Day, Year)
	, the	_ mo.				015	5236		LOWCAR	n,	محصا
	30. Name and eddress of person who	complated causa of	daath (Iten	n 23a) (T	ype, Print)-	. ^			or a		
	30. Name and eddress of person who	1, mo. 11/2	3 W	DOKUN	NR BIK	6 4	ockvillo.	NO TOB	5		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Date of Death Month 17 **Physician** 30 2000 EVA 11 MARIE MHUMRY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M X □ F Months Yrs. 77 May 12, 1922 Maryland Director 214-12-8642 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aparmit. Peges 1 and 2 should be filed within 72 hours after death with it Department of Health end Mental Hygiene.

Important: If frem 27 is marked other than "natural", or items 23a or 2 pry injury or other traumatic event, the Medical Exempter must be as once. 4500 Painters Mill Road 21117 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yas, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 10th Grade -0-Homemaker Own Home 18. Mothar's Name (First, Middle, Malden Surnama) 17. Father's Name (First, Middla, Last) Charles Herbert Baum Florence Anna Lohmeyer 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 17267 19e. Informent's Nema/Relationship (Type, Print) Charles H. Baum, Jr. 315 Tall Spruce Lane; Warfordsburg, Pennsylvania 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1/14/2000 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loring Byers Funeral Directors, Inc. Joh. 8728 Liberty Road; Randallstown, Maryland 21133 23a. Pant. Eplar tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final · RIGHT LOWER disease or condition resulting in death) INBE 2 DAYS Examiner Due to (or as e consequence of) Examiner physician and the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequence of): attending ph for use as t signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Minknown PULMONARY p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed is certificate has director, page 2 1 ☐ Yas 2 🛱 No 1 Yes 2 No el or Attending Physician: T s after death. Il Director: After this certificet ed in by the funeral director, p 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of Certification: 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directorn pletely filled in b 4 Homicide 15 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number inder P mula m.o 000 2000 MANARY 20

JOHINDER P

RANDAUSTOWN

MEHTA

mD

Registrar

State

NORTHWEST

31. Data filed (Month, Day, Year)

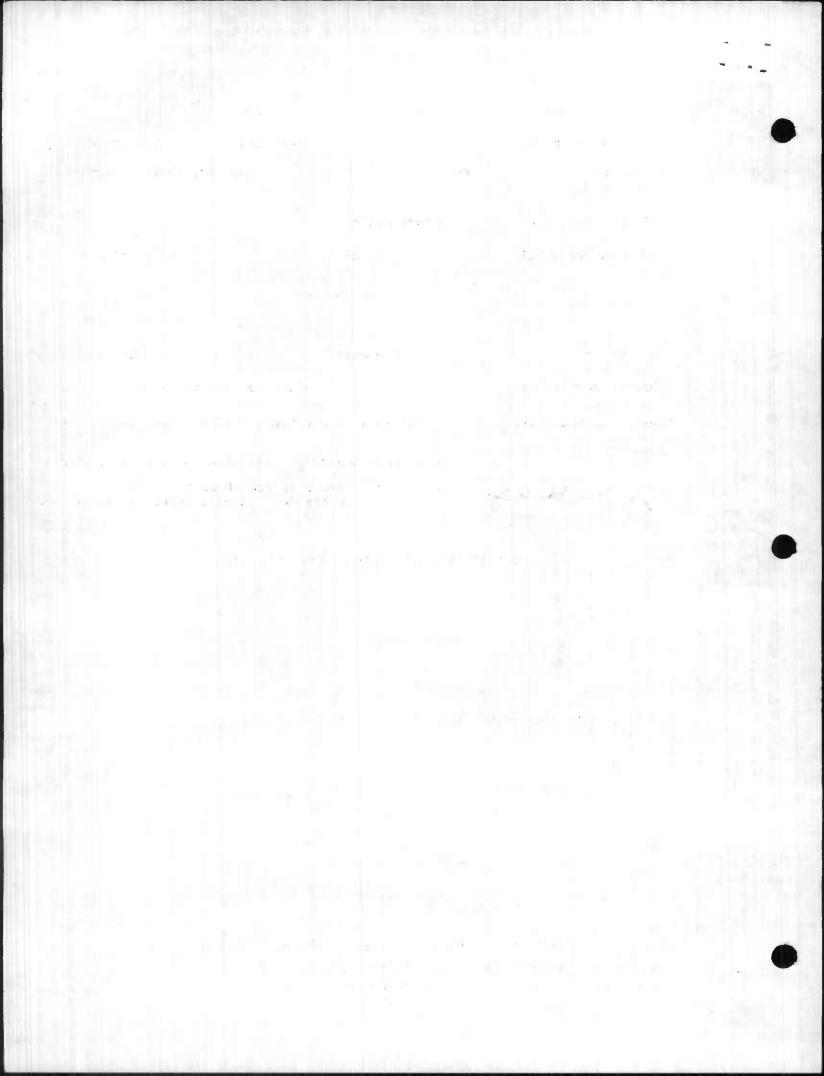
JAN 2 0 2000

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

HUSPITAL

CENTER

32 Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death Month Phillip Riek, Jr. January 17, 2000 5:30 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Pasadena If Under 24 Hrs. 8. De 8656 Cobscook Harbour Anne Arundel If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) Months Days Min. Hours 1 M M 2 □ F Yrs. 220-27-5409 29,1989 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inaide City Limits 1 ☐ Yea 2 S No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8656 Cobscook Harbour 21122 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 B No Specify: Specify 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 4 Dependent N/A N/A 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Phillip B. Riek, Sr. Pamela Anne Long 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pamela A. Peterson (Mother) 8656 Cobscook Harbour Pasadena, Maryland 21122 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 MRemovel from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Cemetery 1/20/00 Greensboro, N. Carolina 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility McCully-Polyniak Funeral Home, P.A. e, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, Approximate List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of) etible Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 2 No 26. Place of Deeth (Check only one) Hospitel:

Examiner sician and burial-transit The law requires that the death certificete be axecuted physician s the burial Box 68760. Physician/Medical . for use signed by the a P.O. Records, by Completed should **page 2** Division of Vitai or Attending Physician: funeral director. Be Certification: To After this death. 24 hours after deat Funeral Director: filled in by

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

2

Funeral

Director

show

Į,

ò

or itsms 23s

the Maryland

72 hours after

filled within

Pages 1 and 2 should be nent of Health and Mental

parmit. Pages 1 and 2 at Chepstraint of Health and Cheportant: if Item 27 is many Injury or other treums once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Pesidenca 6 Other (Specify) 1 | Yes 2 | N6 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Divatural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the lime, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Dete signed (Month, Dev. Year)

derson mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

2448 21401 100 Anderson 31. Date filed (Month, Day, Year) 32. Registrar's Signature

D43236

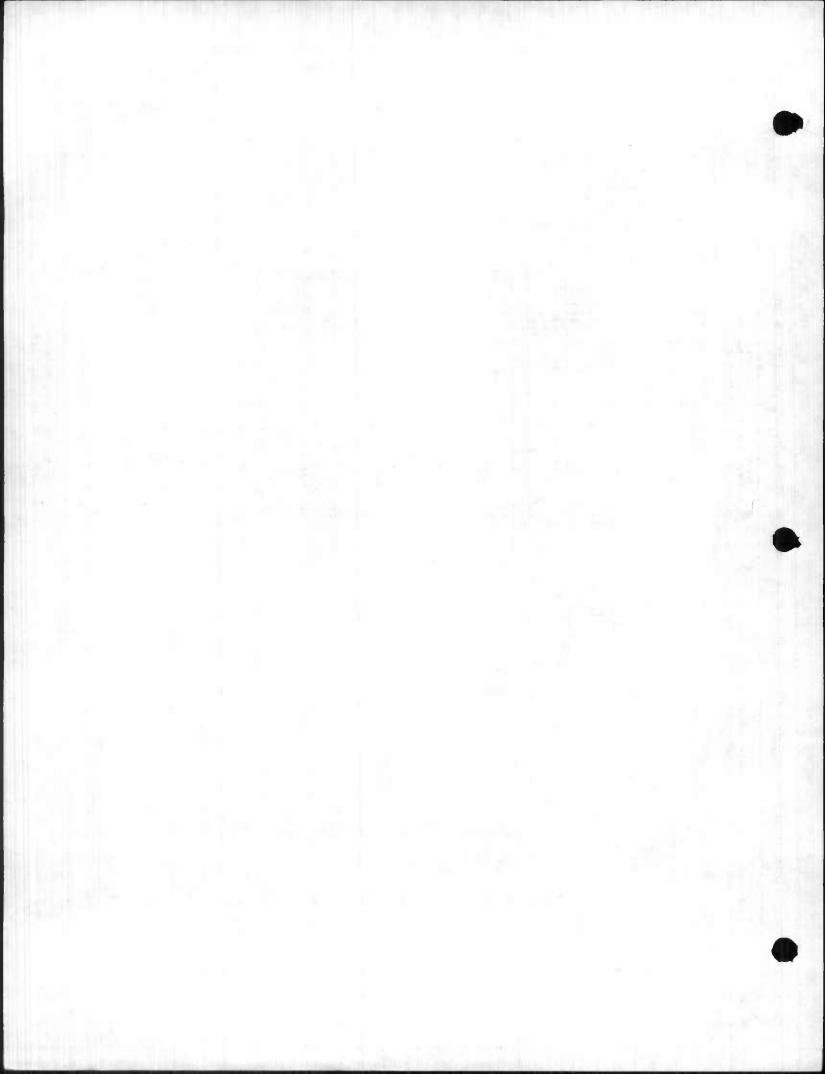
State Registrar

completely

within 2 \$

Medical

Hospital



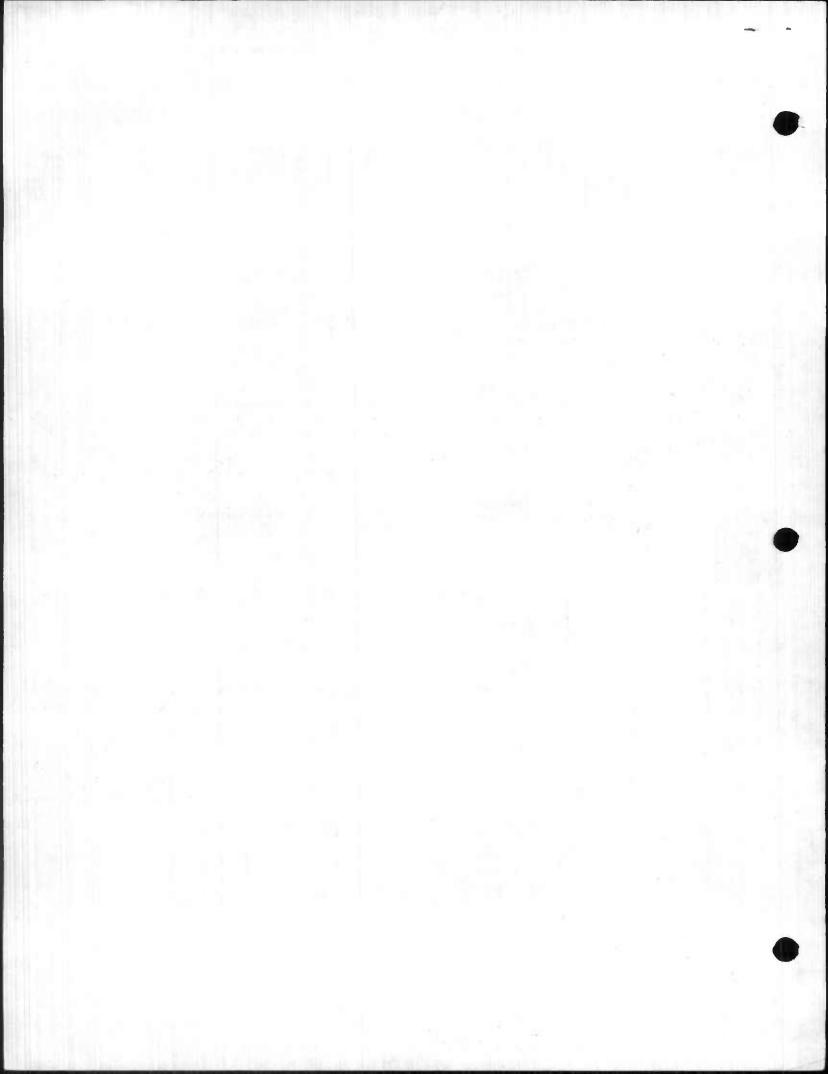
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month **Physician** 17, Violet Leigh Schepler 12:30p.m. 4b. City, Town, or Location of Death 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Multi Medical Center Towson
If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 M 2 M F Deys Hours Director 220-18-5189 July 3, 1915 Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show t ☐ Yes 2 No Maryland Baltimore Pikesville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 204 Sudbrook Lane 21208 "natural", or items 23s Funeral United States Wes Decedent of Hispanic Origin? (Specify Yes or Noting Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, Whita, etc. 72 hours after 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) flied within 7 Hygiene. Other then 'n Elementery/Secondery (0-12) College (1-4or 5+) Department of Health and Mental Hygiens
Treportant: If item 27 is marked other the
ADY injury or other treatments event, the unknown none none 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Frank Schepler Clara Belt 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Market Place Baltimore, MD 21202 Suite 304 Fred Grant (Personal Guardian) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge January 19, 2000 Pikesville, MAryland 22. Name end Address of Fecility Loring Byers Funeral Directors 21. Signeture of Funeral Service Licenses 8728 Liberty Road Randallstown, MD 21133-4784 23a. Part1. Ent. / the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hand reliure. List only one cause on each line. Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical on vestire Minuites Examiner Examiner Vear physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medicai Due to (or es a consequence of): 980 Pert tt. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 94 signed by t 1 Yes 2 No 3 Probably 4 Unknown Dementa by 24e. Was an autopsy performed? 24b. Were sutopsy tindings svaileble prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: after death. Director: After this certifica 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitet: Other: Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Neturet 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after der To the Funeral Director completely filled in by the 3 Suicide 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29e. Certifier 15. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical (Check only one) 29b. Signature and title of certif 29d. Dete signed (Month, Day, Year) 29c. License number Avendant 18,2000 aw 30. Name and address of person who o ed cause of death (ttem 23a) (Type, Print) SchWAQT2 raul 112 MID 31. Dete filed (Month, Day, Year)
JAN 2 0 2000 32. Registrar's Signature State

DHMH 16 Rsv 6/95

Box 68760. Division of Vital Records, P.O.

Registrar

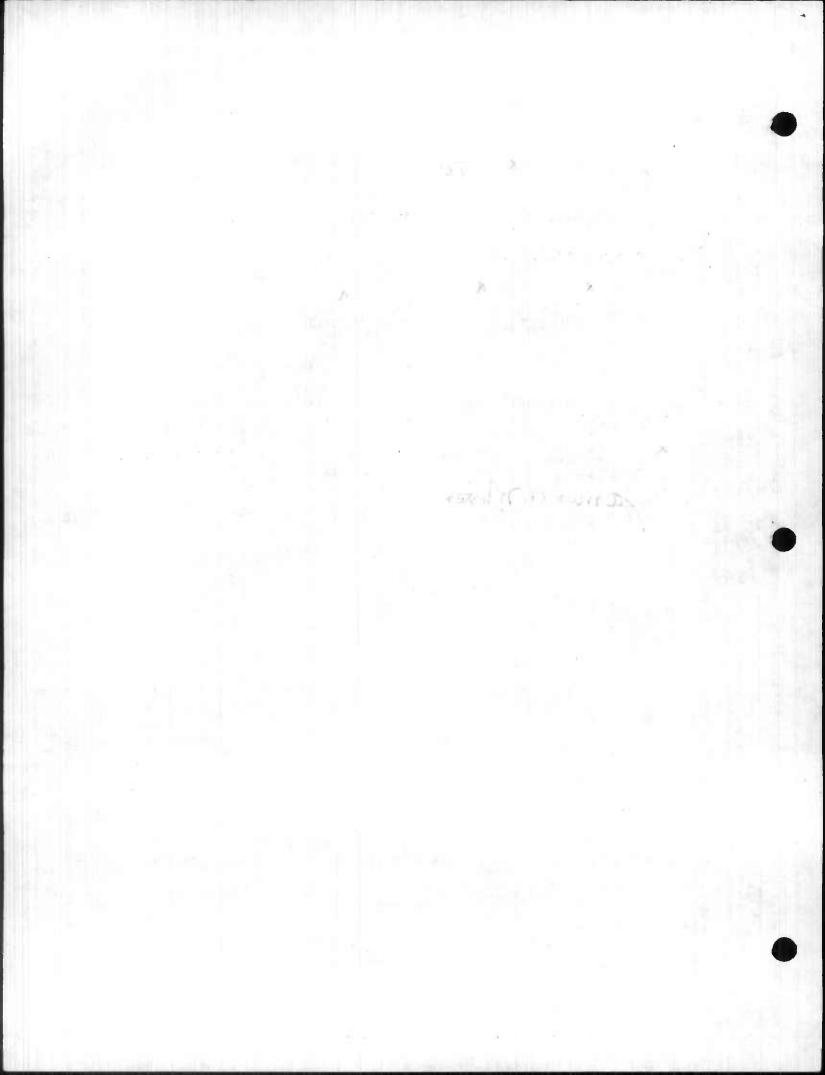


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 945 PM Month 2000 **Physician** Juanita Streams 6. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) N/A If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 20XF 219229227 0 Director 12-24-1929 MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No MD N/A Director BALTIMORE 288-4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerna 23a or 1502 PENNSYLVANIA **AVENUE** Funeral 21217 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: 14. Race - American Indian, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried Specify: BLACK Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) permit. Pages 1 and 2 ahourd be filled w.
Chepariment of Health and Mental Hygien,
Employerant, It less 27 is marked other that
Cany Injury or other traument. 10 LAB TECH CHEMICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum Be JOSEPH HACK CATHERINE JOHNSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) BRENDA JONES/DAUGHTER 337 GWYNN AVE. BALTO., MD. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremelion 3 Removel Irom State GARRISON FOREST 1/21/2000 OWINGS MILLS, MD. 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 23a. Pert 1. Shift the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** metastatic advenil carcinoma /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examine malnutrition physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Cerebro Vascular accident Records. ò 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? Pulmonary Umbolus myo cardial infarction 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was ease referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After thi 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 ☐ Accident or Attending 5 Pending To the Hospital or Attending within 24 hours after death.

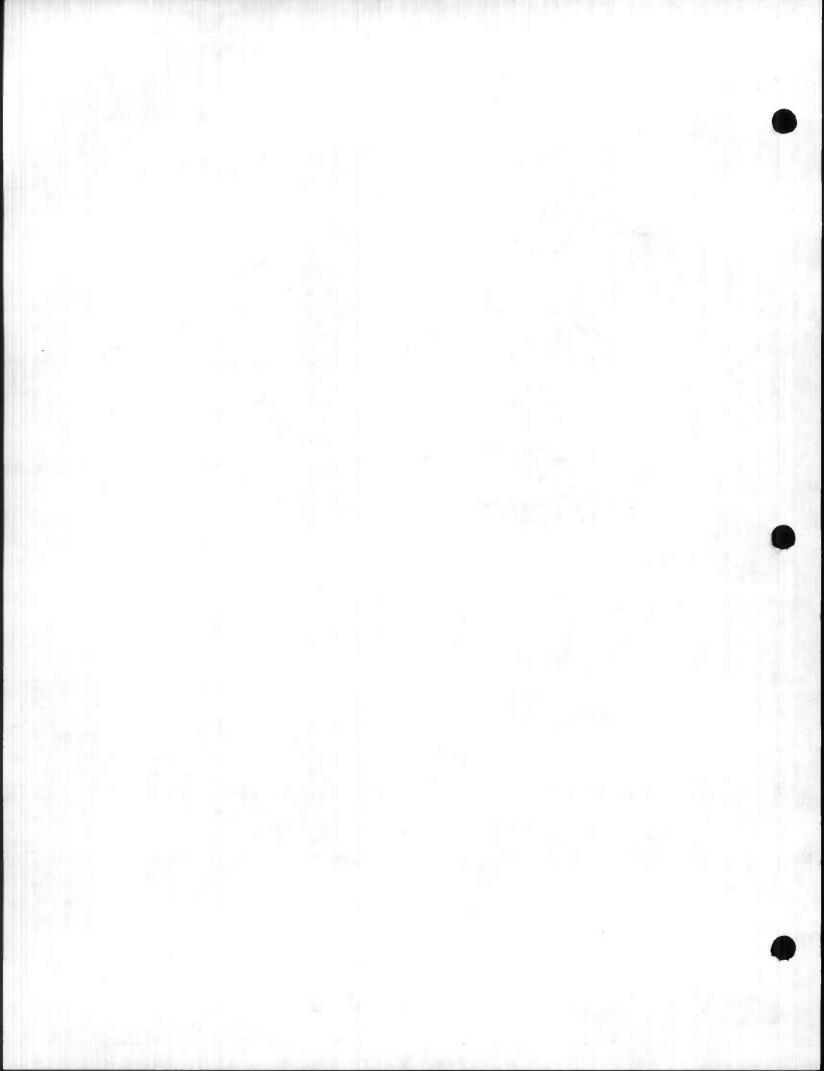
To the Funeral Director: After completely filled in by the funeral process. 1 TYes 2 No investigation 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dele signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (ttem 23a) (Type, Print) St. 5. Baltimore Welne 31. Date Illed (Month, Dey, Year) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** REBA FRAME SCHWARTZMAN 14, **JANUARY** 2000 4:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1450 BEDFORD AVENUE #219 BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 20 F Months Myntry) 94 215-22-1757 **Director** Usual Residence of Decedent the Maryland 10a. Stste 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director BALTIMORE BALTIMORE 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21208 USA 1450 BEDFORD AVE. #219 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②ONo if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Slad within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 the Medical Exami 1 Yes XXNo Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be I Department of Health and Mental I important: If them 27 is marked of any injury or other traumatic eve LOUIS FRAME MOLLY HYKEN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9930 MIDDLE MILL DR. OWINGS MILLS, MD. 21117 RONALD SCHWARTZMAN/SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) 1/18/2000 WOODLAWN, MD. HEBREW YOUNG MEN 22. Name and Address of Facility
SOL LEVINSON & BROS. INC. cel 8900 REISTERSTOWN RD. PIKESVILLE, MD. Part Enter the disease, or completelins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the seuse on each line. Approximate tntervat Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Drohava The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 44 Hertension Box 68760. Que to (or as a consequence of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Stroke 1 Yes 2 Kblo 3 Probably 4 Unknown Division of Vital Records. p Denression 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? page 2 should 1 Yes 22 No 1 Yas 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA edicai Certification: To After this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Panding investigation Injury after death. 1 Yes 2 No 2 Accident the 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 20179 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Court Rd; Daltimory 31. Date fited (Month, Dey, Year) 32. Registrar's Signature State JAN 2 0 Jener 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Year -ndia 71 18:2000 ibio am January 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death System University of Maryland Medical Baltimore If Under 24 Hrs. 8. Date of Birth Hours | Min. | Month, Day, Year If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1□ M 20 F Months 214-40-4318 Yrs. Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md BaHimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe U.SA 00' areu 21211 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give / Year or Detes: 1 Never Married 2 Married Specify: Black 1□ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry School Elementary/Secondery (0-12) College (1-4or 5+) eacher Scharade 4 years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) avence nompson renevieve Donser 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stelle, Zip Code) 10031 19a, Informent's Neme/Reletionship (Type, Print) Sister 345 nenevieve Street New York, New York 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from Stete Kaymonds -24-2000 4 ☐ Donetion 5 ☐ Other (Specify) Funeral Servica Licansee Name and Address of Fecility Ba Ho 300 abast the disease, or complications that caused the death. Approximete Intervel Between Onset end Deeth Do not enter the mode of dying, such as cardiac or respiratory errest Immediete Ceuse (Finel diseese or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

28a-f show

ò

Berra 23s

'natural', or

peemit. Pages 1 and 2 should be filed within 7. Department of hissith and Mental Hygiene. Important: If then 27 is marked other than "n any injury or other traumatic event, the Mediance.

Baltimore, Maryland 21215-0020

Director

Funeral

À

Completed

Be

2

bengis leb ed b page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I

certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Physician/Medical Examiner þ Completed Be Medical Certification: To

29a. Certifier

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Menner of Death 1 Neturel 2 Accident 5 Pending investigation 3 Suicide

6 Could not be determined 4 ☐ Homicide

28a. Dete of Injury (Month, Day Year) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospitel:

1 Nnpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

Location (Street and Number or Rural Route Number, City or Town, Stete)

2 NO

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

Baltimore, MD 21201

29b. Signeture end title of cartifie Jewelli MA

13382

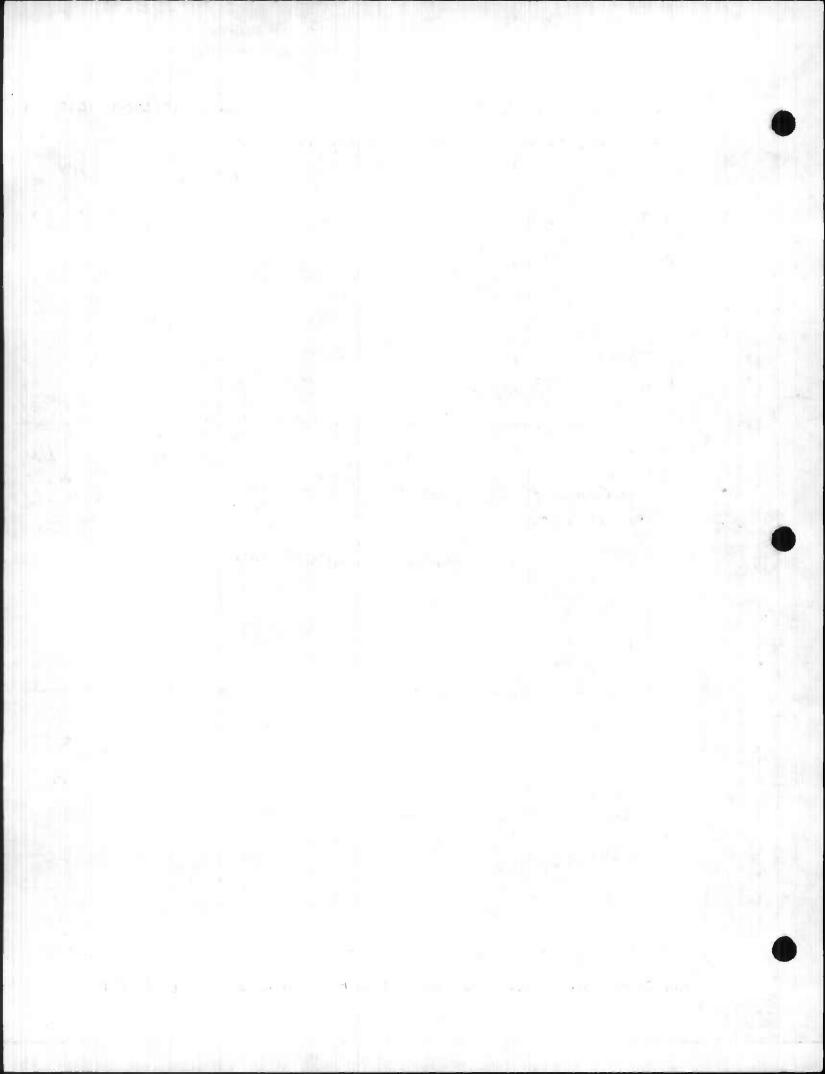
January 18,2000

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Eutaus Street

Jewell, MD Nia 31. Dete filed (Month, Dey, Year) JAN 2 0 2000 lle. #32. Registrer's Signature

18



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Menth Year **Physician** 2000 PANUAR /Medical 4b. City, Town, octocation of Death 4a Facility, Name (If not Institution, give street and number) 4c. County of Death Examiner # Under 8. Date of Birth (Month, Day, Year, 12/08/1919 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 18 M 20 F Yes Maryland Director 218-05-9697 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside Ctty Limits or 28a-f show 1 MYes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 406 N. Linwood Avenue natural, or Nerra 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW II Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Never Merried 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 8th College (1-4or 5+) Cabinet Maker Carpentry 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Health and Montal em 27 is marked o Mary Postanowicz George Szczepaniak 20 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Mingostanti: If Item 27 is any injury or other transcens. Towson, Maryland 21204 619 Round Oak Rd. Diana Linzey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 01/22/00 Baltimore, Maryland Holy Rosary Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Lipenses 22. Name and Address of Fecility David J. Weber Funeral Homes, P.A. eh 401 S. Chester Street Baltimore, Maryland 21231 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each tine. Approximete tntervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner MONICA The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): ROCUTANEOUS Box 68760 Physician/Medical Due to (or as e consequence of): Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yea certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Medical Certification: To 1 ☐ Yes 2 No TE Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1X Neturat 1 ☐ Yea 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide

P.O. Records, Division of Vital within 24 hours a To the Funeral C

> State Registrar

belli filled

To the

29e. Certifier

(Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Day,

of death (Item 23a) (Type, Print)

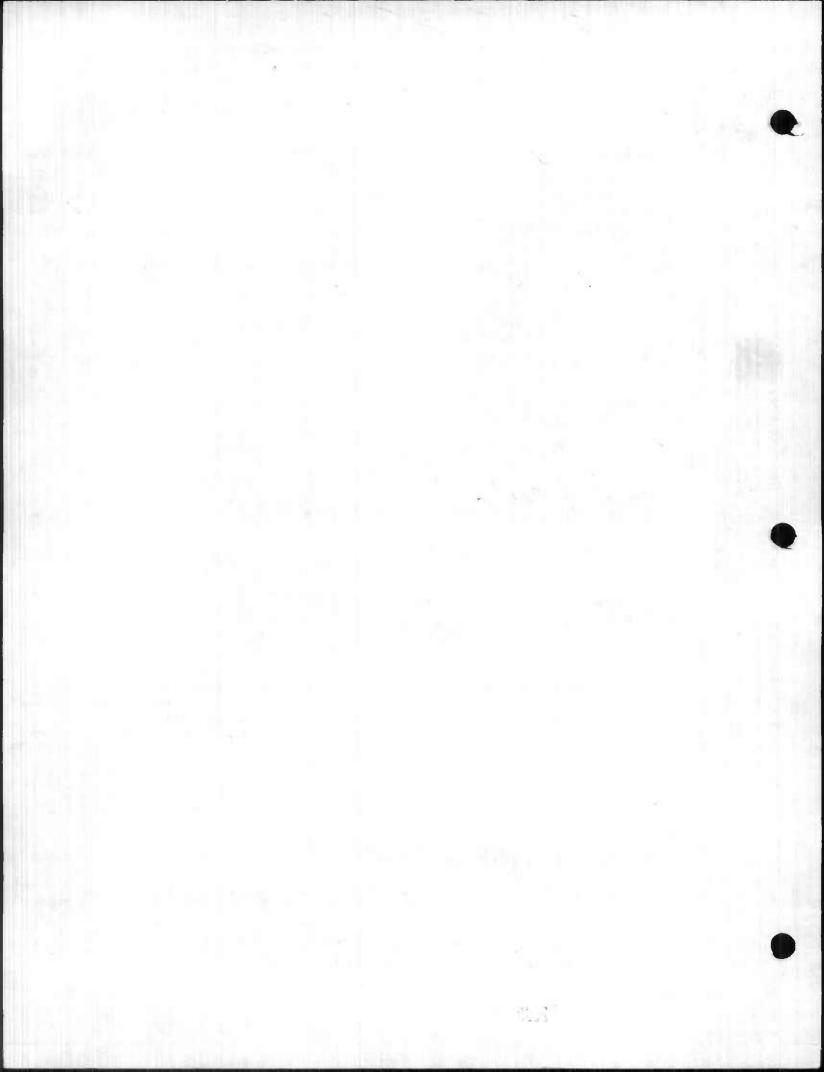
32. Registrar's Signeture

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29c. License number

29d, Date signed (Month, Day, Year)



					of Maryland /		tificate			na ivi	Re	g. No.	U	113	UI							
i.	Physicia /Medic	_	Decedent's Neme (First, Middle		ttie Hanso	n Ta	ylor				2. Data of Death Month Ja	Dey nuary 18,	Yeer 2000	111	of Death 12:30 pm							
	Examin		4a Facility Nama (tf not institutio		umber) Church Road			4	b. City, Tow		llicott City	4c. County		Howar	d							
	Funeral Director		5. Sociel Security Number 503-12-0428	6. Sex 1□ M 2 F	7. Age (In yrs. lest I	birthday) 30 ^{Yrs.}	If Undar 1 Y	Yaar Days	If Under 2 Hours	4 Hrs. Min.	8. Dete of Birth (Month, Dey,) January	(ear) (6, 1920	9. Birthp Coun	lace (Stell try) South	or Foreign Dakota							
The second second	Table Maryland	tor	Usuel Residence of Decedent 10a. Stete 10b. County Marvland	Howard	10c. City, To	own or Lo	cation		Ellicott	City			1		City Limits							
	the death with thems 23a or the must be Funeral DI		10e. Street and Number	and Number 546 Church Road					10f. Zip Code 10g. C													
020			11. Maritel Stetus 1 Navar Married 2 Mar 3 Widowed 4 Divorced	ied 1 Yas	2 No		13. Was Dacedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric				ecify Yes or No- Rican, etc.) 14. Race - Ame Bleck, Whit											
21215-0020	nd 2 should be file lith and Mental Hy 27 is marked other r traumatic event, To Be C	mpleted	mpleted	mpleted	mpleted	mpleted	mpleted	peteldu	mpleted	15. Deceder (Specify only highe Elementery/Secondery (0-12)	T .		(Give	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Teache				working		Business/Industry Education		n
Maryland 2		Be	17. Fether's Neme (First, Middle,	Lest) Severt C. Ha		Ť					(First, Middle, Mi	eiden Surnem Jane Del										
I tower		1	19a. Informent's Neme/Reletions Mr. Frank T.		Spouse		3546 C	hurc			ott City, Mary			Code)								
Baltimore,	Pages 1 mant of He ant: If flen lury or oth		20a. Method of Disposition 1 Burlal 2 Cramation 4 Donetion 5 Other (S		como	tery, crer	sition (Neme netory or otha t. John's (r pleci			Date 21 01/21/2000	Oc. Location -		wn, Stata tt City,								
pai	Depart of the second		21. Signatore of Funerel Sarvice	Licensee	L 110053		. Name end A	Slac	k Funer	al Ho	me, P.A. ia Pike Ellice	ott City, M	ID 2104	43								
),	hysician /Medical	1	Part1. Enter the disease, shock, or heart feiture. List									St,	1		Between and Deeth							
	Examiner	10	disease or condition resulting in death)	a	RCINUM Due to (or es			1742	· 1/1	PCI	KIZ(+)	740		Inu	NTH							
Box 68760,		dical	Sequentially list conditions, if any, leading to amnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or es																	
0.0	the atter	siciar	siciar	Physician/Me	Part II. Other significant condition	ons contributing to	death but not resulting	g in the u	nderlying caus	se giva	an in Part I.		23b. Did tob	acco use cor	ntributs to	the cau	s of death?					
1	5 62	à	CURUNA	2y AR	rery o	15 6	JIZA	_				8 2□ No	3 Pro		Unknown							
Hecords,	has been i a 2 should	Completed			-						24a. Wes an perform	ed?	av	ere autop sileble pri mpletion death?	sy findings or to of cause							
Vital	fificate for, pag	Be Col	25. Was case referred to medica	1					26. Plece	of Deeth	1 ☐ Yas		1[∃Yes 2	Z No							
ö	Niso Niso	10	exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Pendin investi	28e. Det (Mo	Inpatient 2 ER/ e of Injury enth, Dey Year)	Outpetier b. Time of Injury		Other	er: 4 Nur	sing Ho	me 5 Resider 28d. Describe how	nca 8 Oth		y)								
Division	tal or Atta is after de al Directo led in by t	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 208. Plet	ce of Injury - At homa, ding, etc. (Specify)	, farm, str	aet, factory, o	office			28f. Location (Stre City or Town,		er or Rur	al Route N	umber,							
	the Hospi the Euner opietely III	edical	(Check only 2 Medicat	Examiner: On the	be best of my knowled basis of examinetion on the stated.		vestigation, In	my of	pinion, death		ed at the time, da	te and pleca,	end due to	the caus								
•	Total Total	20	290. Signature and tiffs phoening	Won	MD		D 2	29	900	3		d. Dete signed										
	10		30. Nema and address of person	who completed car	OLO APP	ATP.	Print)	F	illi	CUT	TUM	WO.	210	42								

DHMH 16 Rev 6/95

State Registrar

X

X

X

SMOUND D29909 JAPUARY 19, 2000 SMANCER 9501 OLD APPRAY RD ELLICOTICITY MD 21042

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Dacedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jan. 15 2000 Katie Warren 12:15 PM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges General Hospital Cheverly P.G. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 TF 76 419-62-2134 ATabama **Director** Jan 6 1924 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples rule to notified at MD P.G. Temple Hills Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3238 Beaumont Street Funerai 20748 If Pages 1 and 2 should be filed within 72 hours after death imment of Haalih and Mental Hygiene.
That: If item 27 is marked other than "natural", or items 23 mury or other traumalic event, The Medical Exprise manury. USA 12. Was Decedent Ever In U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No If Yes, Give Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: P 3 ☑ Widowed 4 ☐ Divorcad Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Will Warren Ruth Joyner 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Annie J. Thomas (daughter 3238 Beaumont St. Temple Hills, Md 20748 20b. Place of Disposition (Name of 20a. Method of Disposition 20c, Location - City or Town, State Harmony Memorial XBurlal 2 Cramation 3 Removal from State 1/20/00 Hyattsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lican 22. Name and Address of Facility
Austin Royster Funeral Home Shoe 3821 14th St. NW Wash, D.C. 20011 23a Part1 E Approximate Interval Between Onsat and Death the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, **Physician** nispheric Stroke Fewday Immediate Cause (Finel disease or condition resulting in daath) /Medical remisphenic Stroke **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last bunial-trans and P.O. Box 68760. the attending physician ned for use as the buna Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of causa of deeth? paga 2 should Completed 24a. Was an autopsy this certificate has 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case refarred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Othar (Specify) 2 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: Affer 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 \ Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only 29b. Signature and little of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) 6100 ted cause of death (Item 23e) (Type, Print) 30: Name and address of person who comp 14300 Gallant fox# Uroro mD Bowie mo

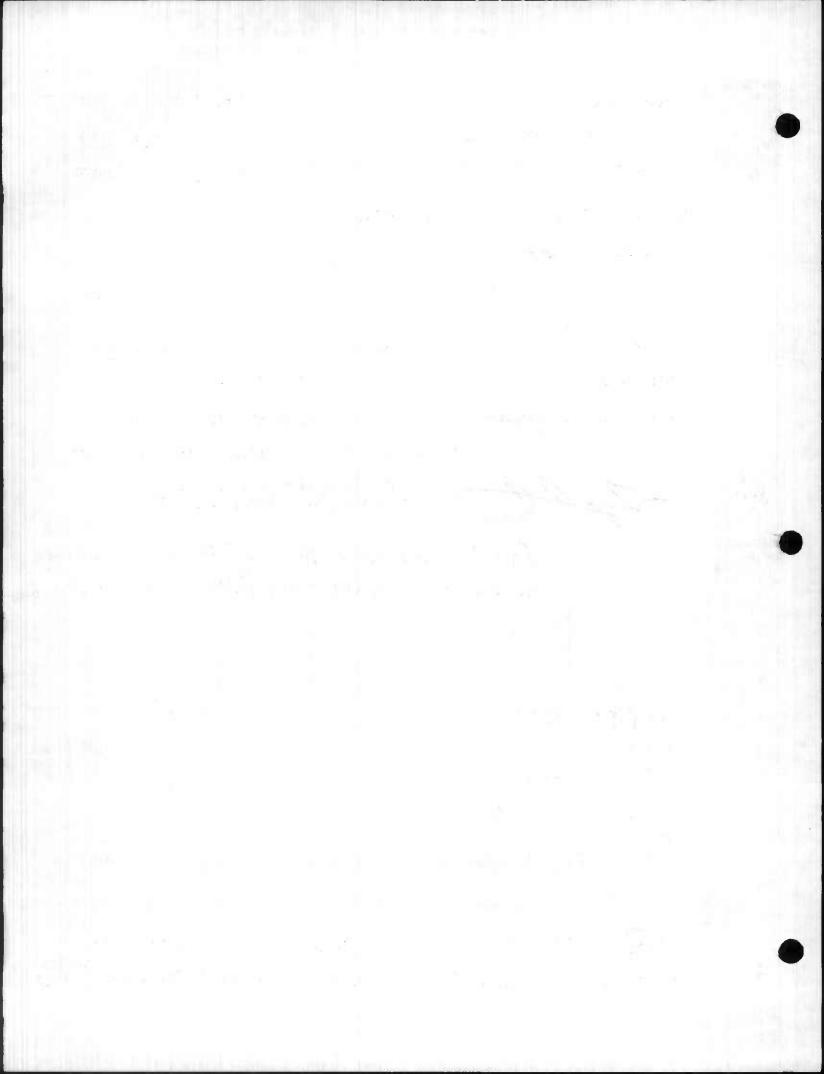
State

Registrar

31. Date filed (Month, Day, Year)

JAN 20

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Watkins January 19, 2000 William 4c. County of Death 4b. City, Town, or Location of Death Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) April 10,1955 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 18 M 20 F Yrs 44 Maryland

1. Decedent's Nama (First, Middle, Last) 3. Time of Death **Physician** Walter 11:25 A.M. /Medical 4a Facility Nama (If not institution, give street and number) **Examiner** 502 Sunset Knoll Road 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 213-64-1553 Usuat Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo 288-1 Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? matthe. 8 21122 502 Sunset Knoll Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Maritai Status 72 hours after 1 Nevar Married 254 Married 1 ☐ Yes 2 No If Yas, Give Yaar or Datas: Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) filed within Elemantary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Manager Dept. of Defence 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit ment of Health and Mental He tent: If Nem 27 is marked oth lury or other traumatic svens Be William Watkins Virginia Boyd 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Susan A. Watkins (Wife) 502 Sunset Knoll Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date Bepartment of Happen and Indiany or of 1 ☐ Burial 2 M Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Greenmount Crematory Baltimore, Maryland 1/20/00 21. Signature of Funaral Sarvice Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. lline 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Physician Immediate Cause (Finat diseasa or condition rasulting in death) /Medical Laamine Due to for as a consequence of): Physician/Medical Examiner for use as the burial-tran Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disease or Injury that in interest and in the cause of the Dua to (or as a consequence of): The law requires that the death certificate be execu that initiated evants resulting in death) Last Dua to (or as a consequence of) Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy page 2 1 Yes 2 No 1 Yes 2 No certificate director, 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Naturat 5 Pending invastigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be datarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

Box 68760, P.0. Records, of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division filled in by

State Registrar

completely

29a Cartifier

29b. Signature and tills of certifie

Date Illed (Morlin, Day, Year)

JAN 2

0

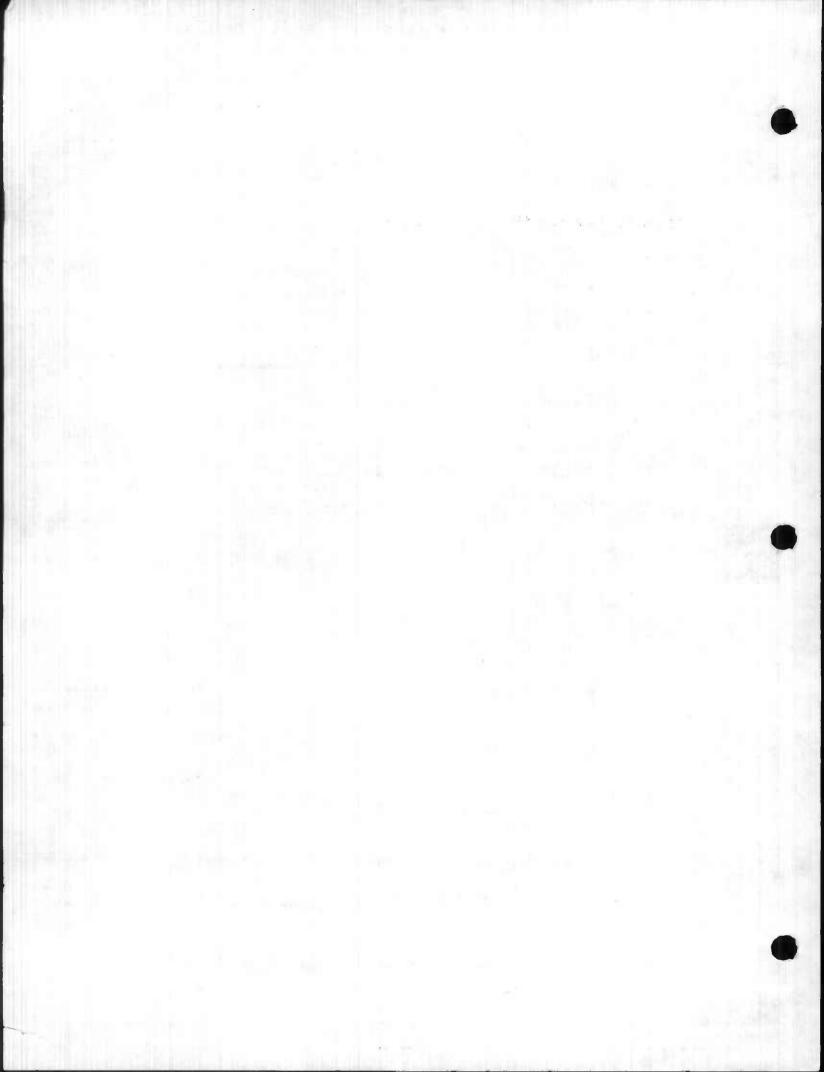
30 Stawie Who address of pe

eled causa of death (Item 238) (Type, Print) M13.160

32. Registrar's Signature

29c License number

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Data signed (Month, Day, Year)

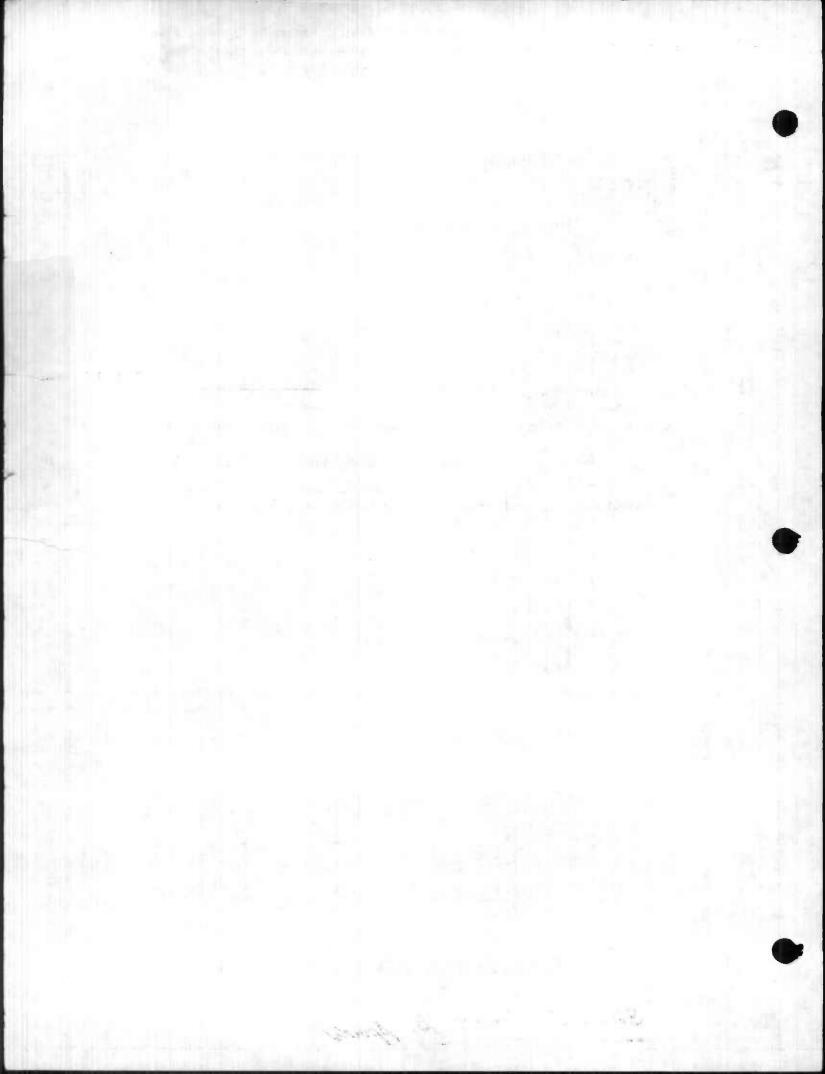


DHMH 16 Rev 6/95

- - - -

1. Sports

ORIGINAL



L. Archer, Sr

tate of Maryland / Department of Health and Mental Hyg	iene	n
Cortificate of Dooth	en No	U

	۱
Physician	
/Medical	

ASP

Damian 4a Facility Nama (If not institution, giva street and number)

MARYLAND SHOCK TRAUMA

1 Decedent's Nama (First Middle Lest)

Reg. No 2. Data of Death Month

19 2000

4c. County of Death

JANUARY

4b. City, Town, or Location of Death

BALTIMORE

3 Time of Death 12:44 A

01305

Physici /Medic Examin	al
Funeral Director	
ahow	

The law requires that the death certificate be executed Box 68760, P.O. of Vitai Records, page 2 this After

1 ☑ Navar Marriad 2 ☐ Married 1□ Yas 2₺ No À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th grade N/A Document Processor other 17. Fathar's Nama (First, Middla, Last) Peges 1 and 2 should be annest of Health and Mental orann: If Item 27 is marked or Wayne Archer Brenda Clark 19a. Informant's Name/Ralationship (Type, Print) Brenda Archer-Suggs 20b. Placa of Disposition (Nama of cemetery, crematory or other placa) Date 20a. Mathod of Disposition X Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) King Memorial Park Bot Paneral Service Licensee 22. Nama and Addrass of Facility March F/H West 4300 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Gunshot Wound of Head disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence ot) Dua to (or as a consequence ot) Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by performed' or Attending Physician: Be 25. Was case ratarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3€ DOA edical Certification: To 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Tima of Injury 1 Natural 5 Pending after death. 1-18-00 1 Yes Invastigation 650 2 Accidant 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, Street, factory, office building, atc. (Specify) 4 Homlcida street within 24 hours a Hospital 29a. Certifier completely To the 29c. Licansa number 29b. Signature and title of certifie JANUARY 19,2000 O.C.M.E 30 Nama and addrass of pe pleted causa of death (Item 23a) (Type, Print) enhis 111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signatura

Geneva

If Under 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Min 1 X M 2□ F 212-08-9406 Yrs 24 12-9-1975 Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits filed within 72 hours after death with the Mary Md 1 X Yas 2 No N/A Baltimore r than "natural", or Items 23a or 28a-f Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 822 Newington Avenue 21217 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 X No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Biack, Whita, atc. Baltimore, Maryland 21215-0020 Black 16b. Kind of Businass/Industry Associated Management Services Inc 18. Mother's Nama (First, Middla, Maidan Sumama) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10204 Marriottsville Road Randallstown, Md 21133 20c. Location - City or Town, State 1-22-2000 Randallstown, Md Wabash Avenue Baltimore, Md 21215 Approximata Interval Batween Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy Yas 2 No 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred Division subject shot 281. Location (Street and Number or Rural Routa Number, City or Town, State) gop Blk Nowing to n Bathmore, M. 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year)

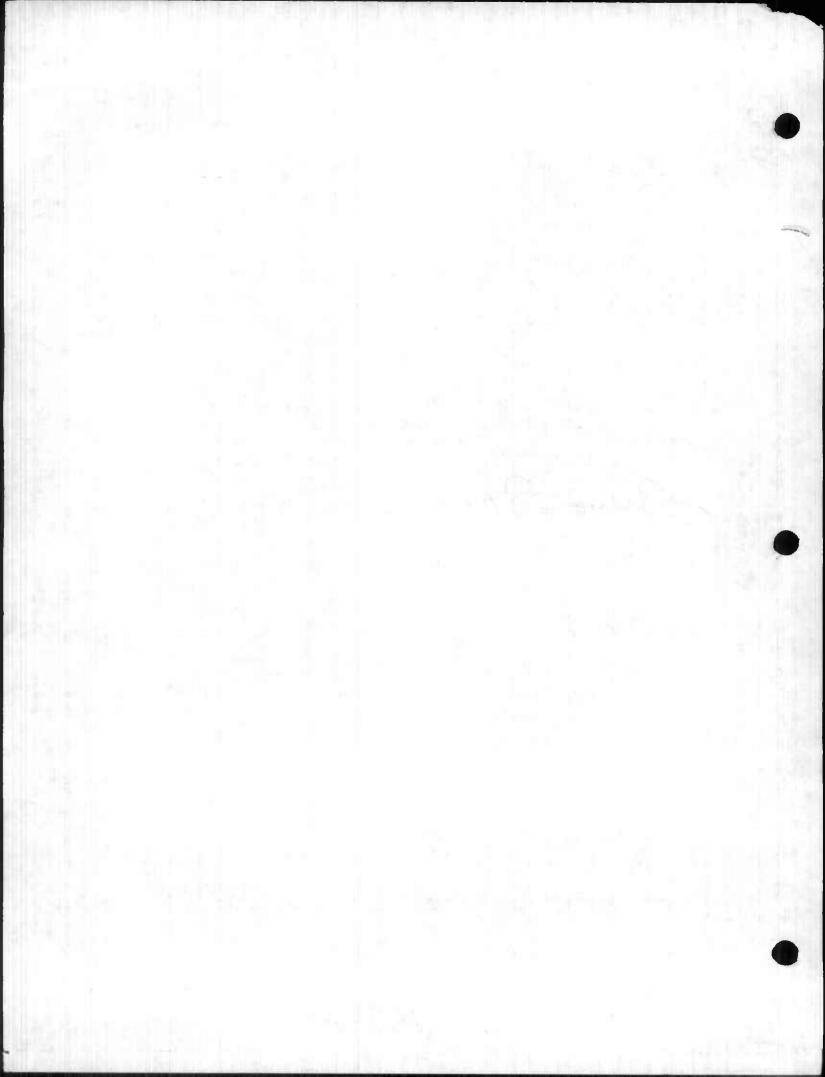
DHMH 16 Ray 6/95

State

Registrar

MMM O - DOGS

31. Data tiled (Month



an Mary Abs	st, Middle, Last	State of PER ME					2. Date o		Year	3. Tims of Dea
er 4a Facility Name (I not)	emvertal	street as driving	bent.			4b. City, Town	JANU or Location of D	JARY 16	2000	10:22
5. Social Security Number	R GEN	ERAL HO	SPITAL	-0-		CAMBR			inty of Death LBOT RCHESTE	R
219-52-78	6. Se	M 2016	Age (In yrs. 48	lest birthdey) Yrs.	If Under 1 Ye Months Dey	14				ce (Stete or For
Usuel Residence of Dece	dent		140.00				700	13,1931	Md.	
	albot			y. Town or Loc	ation				100	d. Inside City Lin
10e. Street and Number		10f. Zip Code					of What Countr	1 ☐ Yes 2 🔀		
11903 Rai]					2162	5	or what country	y r		
11. Maritel Status 1 Never Married 2	Married	Armed Force 1 Yes 2	ent Ever in U, es?	S. 13. W	es Decedent of Yes, specify Cu	Hispenic Origin? ban, Mexican, Po	(Specify Yes or lerto Rican, etc.)	No- 14. R	lece - American	
3 ☐ Widowed 4 ☐ D		If Yes, Give Yeer or Date	-	11	Yes 2 N	Specify:		Spec		
(Specify only	ecedent's Educ highest grade	completed)		16a. Decede	nt's Usual Occ	upation e during most of	working	16b. Kind of	Business/Indu	
Elementary/Secondery (0-12)	College (1-4	,		1101 430 1011	60)				
17. Father's Name (First, A			1.	Assemi	DIA PI	ne Work	er lame (First, Midd	General Genera	ral Mo	tors
John D							e Wehr		277.07	
19e. Informent's Neme/Re Donald Abs	letionship <i>(Typ</i>	e, Print) Husba:	nd	19b. Mailing	Address (Stree	et end Number or	Rurel Route Nur	nber, City or Tow	n, State, Zip Co	ode)
20e. Method of Disposition			20h Pl	CA OF LUSDOSI	ion (Nama of	road Av				
1 ■ Burial 2 □ Crem 4 □ Donetion 5 □ Ot	ation 3 Re	moval from Sta	te Ce	aklawr	tory or other pla	ece)	Jan		- City or Town	, State
21. SignetUter of Funeral &	ervice bycenses	15	1		Name end Addr	ess of Fecility	Jan 22,20	00 Di	ındalk	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant con	{			s e conseque					1	
Pert II. Other significant co	d.	buting to doub	h							
	Tallione Contra	outing to death	out not resulti	ng in the unde	rlying cause giv	ren in Pert I.		tobacco uss co Yes 2□ No		
								1168 2LING	3 Probabi	y 4 ☐ Unkno
								s an autopsy	24b. Were a	utoney lindene
							24a. Wei	ormed?	comple	le prior to
							peri		comple of deat	ple prior to stion of cause h?
	dical					26. Piece of De	peri	Yes 2□No	comple	ple prior to stion of cause h?
25. Wes case relerred to me examiner?	Hos	1 X Inpati			B DOA Oth		ath (Check only	Yes 2 No	comple of deat	ple prior to stion of cause h?
25. Wes case relerred to me examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pe	Hos	pital: 1 ☑ Inpati 28a. Date of Inj (Month, De	ury 28	b. Time of Injury	28c. Injun Work	er: 4□ Nursing I / et </td <td>ath (Check only</td> <td>Yes 2□No</td> <td>comple of deat</td> <td>ple prior to stion of cause h?</td>	ath (Check only	Yes 2□No	comple of deat	ple prior to stion of cause h?
5. Wes case referred to me examiner? 1 TXYes 2 No 7. Manner of Death 1 X Natural 5 Pe 2 Accident in 3 Suicide 6 Cc	Hos ending vestigation	1 X Inpati 28a. Date of Inju (Month, De 28e. Piece of In	y Year) 28	b. Time of Injury	28c. Injun Work	er: 4 Nursing I	ath (Check only Home 5 - Res 28d. Describe	Yes 2□ No one) idence 6 □Oth how injury occur	comple ol deat	ole prior to stion of cause h?
25. Wes case relerred to me examiner? 1 To Yes 2 No 17. Manner of Death 1 Natural 5 Pe 2 Accident Int 3 Suicide 6 Cc 4 Homicide	ending restigation buld not be termined	28a. Date of Inj. (Month, De 28e. Plece of Inbuilding, et	jury - Al home c. (Specify)	b. Time of Injury	28c. Injun Work 1 1	er: 4 □ Nursing I / et ⟨? Yes 2 □ No	ath (Check only) Home 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur Street end Numb wn, Stete)	ocomple of deat	le prior to stition of cause h? s 2 No
25. Wes case relerred to me examine? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident incompared to me death 3 Suicide 6 Cd 4 Homicide de	ending prestigation and not be termined	1 X Inpati 28a. Date of Inj (Month, Da 28e. Plece of In building, et	jury - Al home c. (Specify)	b. Time of Injury	28c. Injun World 1 []	er: 4 Nursing I (et (? Yes 2 No	ath (Check only Home 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur Street end Numb wn, Stete)	ocmple of deat	le prior to station of cause h?
25. Wes case referred to me examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Per 2 Accident in Contact de	ending prestigation and not be termined	1 X Inpati 28a. Date of Inj (Month, Da 28e. Plece of In building, et	jury - Al home c. (Specify)	b. Time of Injury	28c. Injun World 1 []	er: 4 Nursing I	ath (Check only dome 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur Street end Numb wn, Stete) cause(s) end ma date and place, s	er (Specify) red nner as stated and due to the	le prior to station of cause h? ss 2 No
25. Wes case referred to me examine? 1 (X) Yes 2 No 27. Manner of Death 1 (X) Natural 5 Pe 21 Accident inv 3 Suicide 6 Co 4 Homicide de	ending prestigation and not be termined	1 X Inpati 28a. Date of Inj (Month, Da 28e. Plece of In building, et	jury - Al home c. (Specify)	b. Time of Injury	28c. Injun Work 1 1 factory, office	er: 4 Nursing I	ath (Check only dome 5 Res 28d. Describe 28f. Location (City or To	Yes 2 No one) idence 6 Oth how injury occur Street end Numb wn, Stete)	er (Specify) red One of Rural Router or Rural Router or Rural Router or Rural Router of Rural	le prior to altion of cause h? s 2 No ute Number, cause(s)

00-0274-041

ORIGINAL

Ariginal
Mever founce

Duplicate used
until original
us clocated.

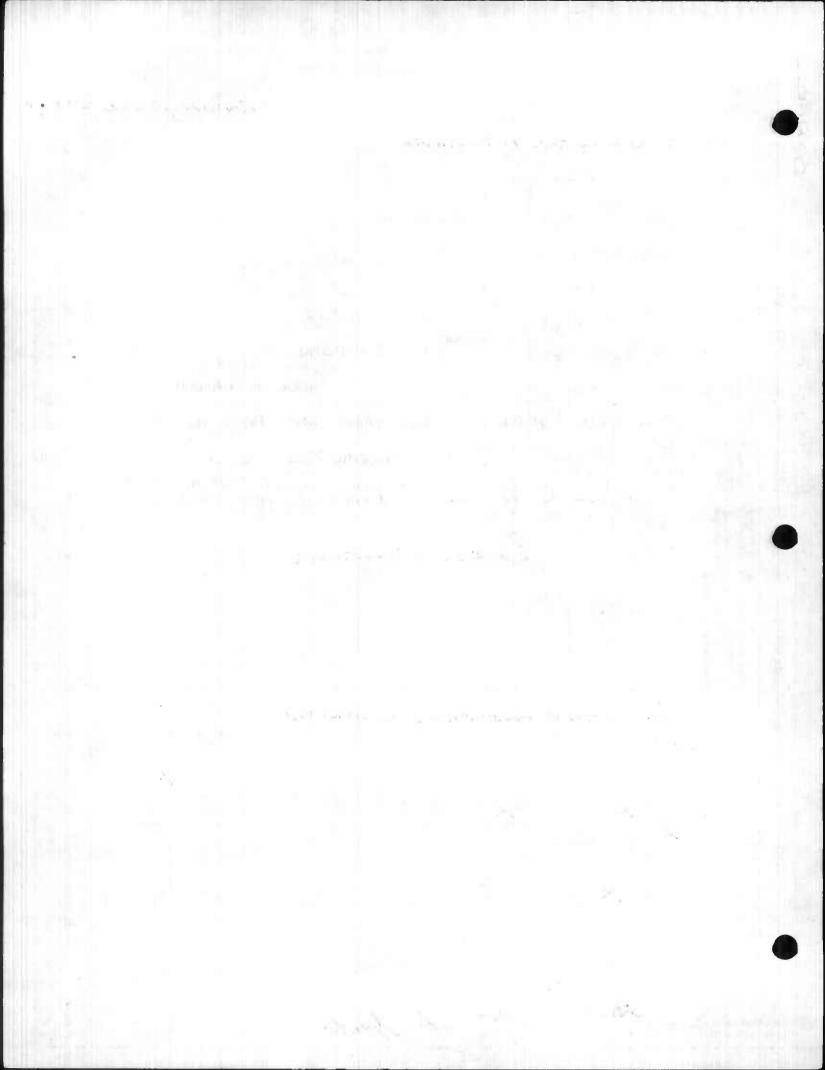
3/9/00

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 4b. City, Town, or Location of Death County of Death EARLINE MARGARET BURDNELL /Medical 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE DINAT HOOP ITAL of DALTIMORE If Under 1 Year 8. Data of Birth (Month, Day, Year) 01-23-24 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number Days **Funeral** 10 M 20 F Months Hours 13 Director 20. MD Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No NIA MD Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2519 LIBERTY USA HEIGHTS AVENUE 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WK MO. GLASS LAB TECHNICIAN 12 TH GRADE 18. Mother's Neme (First, Middle, Meiden Sumama) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Item 27 is marked off 86 MOUNT JOSEPH DAVIS ALICE BUCHANAN 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. tnformant'a Neme/Relationship (Type, Print) CLARKS LANE GLORIA CURRY SISTER BALTO, MU. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 11-20-2000 RANDAUSTOWN 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hadar failure. List only one cause on each line. 21229 Approximata Interval Between Onset and Death **Physician** /Medical tmmediata Cause (Final disease or condition resulting in death) OWEL NEARCTIO Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical the Due to (or as a consequence of): for use as 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown ALZHEIMER DEMONTIA Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate has 1 ☐ Yes 2 X No 1 ☐ Yas 2 ☐ No of Vitai Be 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To s after deeth.
I Director: After this
d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of tnjury - At homa, farm, alreet, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 2000 RES-000 Jonuary 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Justin Chamberli Brown, mo 31. Date filed (Month, Day, Year)
JAN 2 1 2000 32, Registrar's Signature

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

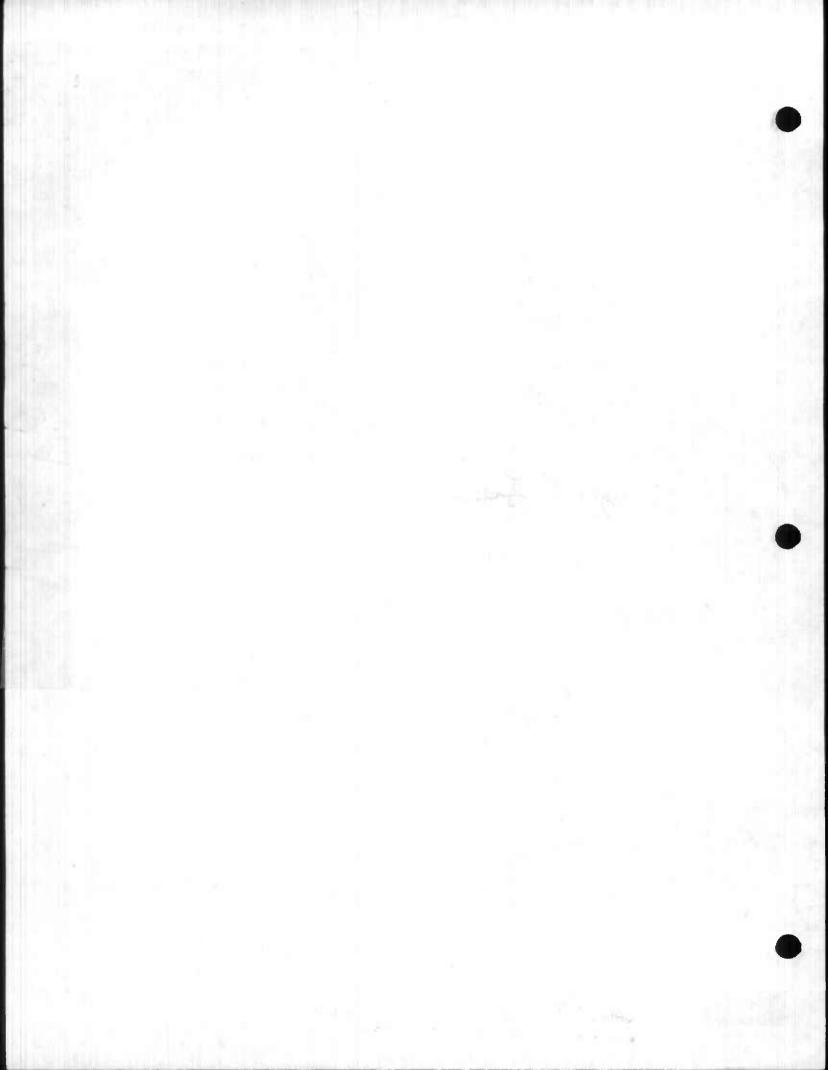
State of Maryland / Department of Health and Mental Hygiene

00 01308

		Reg. No.	
	Decedent's Name (First, Middle, Last) 2. Date of D		3. Time of Death
ician		1 gay 2	Year 10:30 P.
dical niner	4n City Town of posting of postin		of Death
l r	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D	lirth	9. Birthplace (Stata or Foreig Country) MA A
	Usual Residence of Decedent	1 10	I · V I · o
tor	10a. State 10b. County 10c. City, Town or Location NA Battamore		10d. fnside City Limit
Director	10e. Street and Number 10f. Zip Code	10g. Citizen of V	Vhat Country?
0	1010 W. Battimore St 21223	US	A
by Funeral	11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcea? 1 □ Never Merried 2 □ Married 1 □ Yes 2 □ No If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yas 2 □ No If Yas 2 □ No Specify:	lo- 14. Rac Blac Specify	a - Amaricen Indian, sk, Whita, atc.
P	3 Wildowed 4 Divorced Year or Dates:		BIAU
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired)		usiness/Industry
S	grade N/A Domestic		ume
Be	17. Father's Name (First, Middle, Last)		
Lo	o Thomas Janes, SR Mary G	ass a	vey
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num		
	Barbara Townes (sister) 8123 Church Ln, 13	attinun	emo 2124
	20a. Method of Disposition 20b. Place of Disposition (Name of Date completes separation (varieties per place)		City or Town, State
	4 Donation 5 Other (Specify) King Memorial Park 101-ZZ-Z	poo Ran	dallstown, m
	21. Signature of Funeral Service Licensee 22. Name end Address of Facility Vaughan Correct Funeral Service Licensee 23. Part Falor Madifense or complications that several the death Do not extent the mode of duing such as parties or respiratory.	seral 5	ervice
		arrest,	
	shock, or heart failure. List only one cause on each line.		Interval Between Onsat and Death
н	Immediate Cause (Final		
-	disease or condition resulting in death) a. SICCP HPNEG		12/12
7	Due to (or as a consequenca of):		
든	· mondid obesity		177745
cal Examiner			
n/Medical			
by Physician	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did	d tobacco use co	ntribute to the cause of deat
3	Part II. Other significant continuous continuous to death but not lastitudg in the underlying ceuse given in Part I.		,
0		Yea 2 No	3 Probably 4 Unkno
>	Seizure Asorder		
leted by	Serve asorder Smoker 24a. Wa per	as an autopsy formed?	available prior to completion of cause
mpleted by	Serve Dorde	formed?	available prior to completion of cause of death?
Completed	Smaker 24a. Wa per	as an autopsy formed?	available prior to completion of cause
Be Completed	24a. Wa per 25. Was case referred to medical avarpinar? 26. Place of Death (Check only avarpinar)	ormed?	available prior to completion of cause of death?
Completed	24a. Wa per 25. Was case referred to medical axaminar? 10 Yes 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Ret	Yes 2/2 No	available prior to completion of cause of death?
To Be Completed	24a. Wa per 25. Was case referred to medical axaminar? 1 Ves 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Ret	Yes 2/2 No	available prior to completion of cause of death? 1 Yes 2 No
To Be Completed	24a. Wa per 25. Was case referred to medical axaminar? 1 Ves 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Ret	Yes 2 No ✓ one) sidenca 6 □Oth	available prior to completion of cause of death? 1 Yes 2 No
To Be Completed	24a. Wa per 25. Was case referred to medical axaminar? 1 Ves 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Ret	Tormed? Yes 2 No Yone) sidenca 6 □Oth he how injury occur (Street and Numb	available prior to completion of cause of death? 1 Yes 2 No
To Be Completed	24a. Wa per 25. Was case referred to medical axaminar? 1 Ves 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Ret	Tormed? Yes 2 No Yone) sidenca 6 Oth e how injury occur (Street and Numbown, State)	available prior to completion of cause of death? 1 □ Yes 2 No er (Specify)
Certification: To Be Completed	25. Was case referred to medical axaminar? 1 Yes 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 EP/Outpetient 3 DOA Other: 4 Nursing Homa 5 Reserved in North Part 1 Nursing Homa 5 Reserved in North Part 2 North Part 2 North Nursing Homa 5 Reserved in North Nort	one) Sidenca 6 □Oth how injury occur (Street and Numbown State) Cause(s) and ma	available prior to completion of cause of death? 1 Yes 2 No er (Specify) red per or Rural Route Number,
edical Certification: To Be Completed	25. Was case referred to medical axaminar? 1	Yes 2No Yone) sidenca 6 Oth s how injury occur (Street and Numb own State) A e cause(s) and ma	available prior to completion of cause of death? 1 Yes 2 No er (Specify) red per or Rural Route Number, anner as stated. and due to the cause(s)
Certification: To Be Completed	25. Was case referred to medical axaminar? 1	Yes 2No Yone) sidenca 6 Oth s how injury occur (Street and Numbown State) A cause(s) and me s, date and place,	available prior to completion of cause of death? 1 Yes 2 No er (Specify) red per or Rural Route Number, anner as stated. and due to the cause(s) d (Month, Day, Year)
edical Certification: To Be Completed	25. Was case referred to medical axaminar? 1	Yes 2No Yone) sidenca 6 Oth s how injury occur (Street and Numb own State) A e cause(s) and ma	er (Specify) red er or Rural Route Number, anner as stated. and due to the cause(s) d (Month, Day, Year)
edical Certification: To Be Completed	25. Was case referred to medical axaminar? 10 Yes 2 No 27. Manner of Death 1 Notatural 5 Panding Investigation 3 Suicida 6 Could not be determined 28a. Date of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 24a. Was per 24b. Was case referred to medical axaminar? 1 Inpatient 2 ER/Outpetient 3 DOA Other: 28b. Time of Injury - Work? 1 Nort? 28b. Time of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28d. Describe to the City of Tothe best of my knowledge, death occurred at the time, date and place, and due to the Check only and manner stated. 29b. Signature and title of certifier 29c. License number	one) sidenca 6 Oth he how injury occur (Street and Numbown State) e cause(s) and man, date and place, 29d. Date signe	available prior to completion of cause of death? 1 Yes 2 No er (Specify) red per or Rural Route Number, anner as stated, and due to the cause(s) d (Month, Day, Year)
edical Certification: To Be Completed	25. Was case referred to medical axaminar? 1	one) sidenca 6 Oth he how injury occur (Street and Numbown State) e cause(s) and man, date and place, 29d. Date signe	available prior to completion of cause of death? 1 Yes 2 No er (Specify) red per or Rural Route Number, anner as stated. and due to the cause(s) d (Month, Day, Year)

DHMH 16 Rev 6/95

養実す クラー

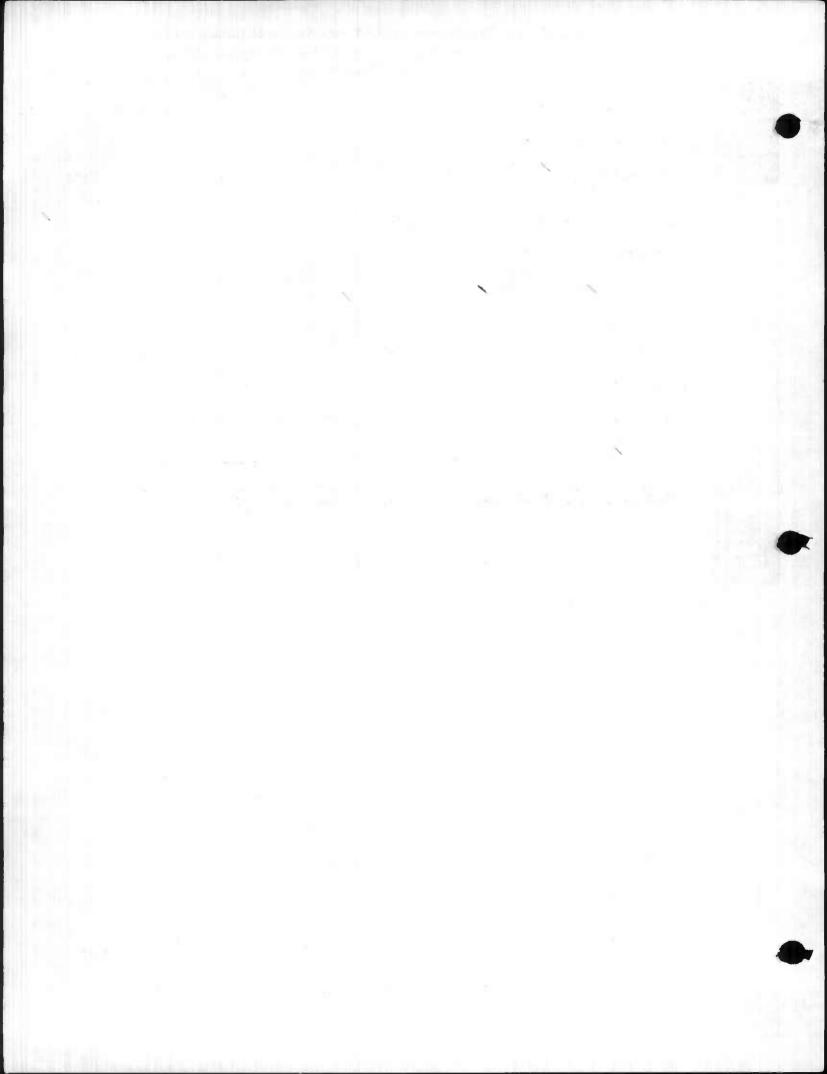


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

							rtificate o	f Death		Reg. No.	UU	1309
Physicia	an	Decedent's Name							2. Date of D Month	eath Day	Year	3. Tima of Death
/Medica				ll Bauer					1		2000	7:30 P.M
Examine	er	4a. Facility Name (/							r Location of Dea	th 4c. County	of Death	
				Hopkins	т —			Baltim			N/A	
Funeral Director		5. Social Security N 214-26-1 Usual Residence of	181	6. Sax 1 2 M 2 □ F	276.5	yrs. lest birthday) 9 Yrs.	If Undar 1 Yas		n. (Month, D	irth le <i>y, Year)</i> 28/1930		aca (Stete or Foreign ry) York
death with the Maryland rms 23a or 28a-f show r must be notfried at	_	10a. Stata	10b. County		10c.	City, Town or Lo					10	d. Inside City Limits
M es M	cto	MD		imore		Dunda	1k					1 ☐ Yes 2 ☑ No
1 P P P	5	10e. Street and Nur					10f. Zip Code			10g. Citizen of	What Country	ry?
23a	a	8618 San	dy Pla:	ins Rd.				21222		U.S.	Α.	
urs after al', or its	by Funeral Director	11. Marital Status 1 Naver Marri 3 Widowed	-	ried 1 Tyes	ecedent Ever I Forces? s 2 No Give r Dates:		Was Decedent of If Yes, specify Cu 1 Yes 2 N	f Hispanic Origin? uban, Maxican, Pue o Specify:	(Specify Yes or N erto Rican, etc.)	o- 14. Rad Bia Specif	ca - America ck, Whita, e	tc.
Hygiene. ther then "natur	Completed	(Spec	ify only highe	t's Education st grade complete College	d) (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of w	orking	16b. Kind of B	usiness/Indu	ustry
of other event,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Middle			
	ToB	Charles 1							Van Wag			
the train		Joyce Bar						etend Number or i lains Rd		ber, City or Town, $1\mathrm{k}$, MD 2		Code)
Department of Healt Important: If Item 2 any Injury or other			Cremation	3 🗆 Ramovai from	m Stata		metory or othar p		Date	20c. Location		vn, State
ortant Injury		4 ☐ Donation 21. Signature of Full			B		e/Washin 2. Name and Add	agton Cr.	1/21	Laurel	L, MD	
Depe Impo		Dem	and)	dal	male.			shton-Ma ow Sprin				
g physicie es the bu	/Medical Examiner	disease or condition resulting In death) Sequentially list condition and the cause. Enter Undate Cause (Disease or that initiated events rasulting in death) L	nditions, mediate rlying njury	a b c f	Due to	o (or as a consec	juenca of):	dion	J. P.	al wy		
e ettendin	clan	Part II Other elanifi	cant conditio	na contributing to	doath but not	roculting in the u	ndadvina esues	nhan In Bart I	29h Dia	I tabassa was sa	1	Manager 20 de 200 0
deteche	Physician/M	Part II. Other signifi	cam conditio	and contributing to	death but not	resulting in the u	ndenying cause (given in Part I.		Yes 2 No		the causs of death?
hes been signed by the (ge 2 should be deteched	Completed by									s an autopsy ormed?	avai	re autopsy findings llable prior to spletion of causa eath?
ate hes b	Con								10	Yes 20kNo	1 🗆	Yes 2□ No
s certificate director, peg	Be	25. Was case referrexaminer?	ed to medicai					26. Place of D	eeth (Check only	one)		
this certific	2	1 Yes 2 K	No	Hospital: 1 [Inpatient 2	ER/Outpatier	t 3 DOA	Other: 4 Nursing	Home 5□Res	idance 6 Oth	er (Specify)	
After the funere		27. Menner of Death 1 Natural	5 Pendin	g (Mo	e of Injury onth, Day Year	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how Injury occur	red	
within 24 hours effer deeth. To the Funeral Director: Affer completely filled in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could r	not be 28e. Pla	ce of Injury - A Iding, etc. (Spe	at home, farm, str ecify)	eet, factory, office		28f. Location City or To	(Street and Numi own, State)	ber or Rural	Route Number,
Funer Funer tely fill	Medical C	29a. Certifier (Check only one)	1 ⊠ Certifyin 2	Examiner: On the	ne best of my libasis of axam	knowledge, death ination and/or in	n occurred at the vestigation, in my	time, date end ple opinion, death occ	ce, and due to the curred at the time	ceuse(s) end mand date and piace,	anner as sta and due to t	ited. tha cause(s)
within 2 To the comple	Me	Sarces recommende	file of certifier		anter Stated.		29c. Lice	nse number		29d. Date signe	d (Month. D	lay, Yearl
\$ ⊢ 8		611	- 7/	75	-	2m		20640	g	1/2.	1-	
0		30. Name and addre	ss of person	who completed ca	use of death (I	tem 23e) (Type,		7		1/1	1 200	00
		Johr	W. E	Bowie, I	M.D.	Greate	r Balt	imore M	edical	Center		
State Registra		31. Date filed (Monti	n, Day, Yeer)	32.	Registrar's Si	gnature 4	boark					

DHMH 16 Rev 6/95



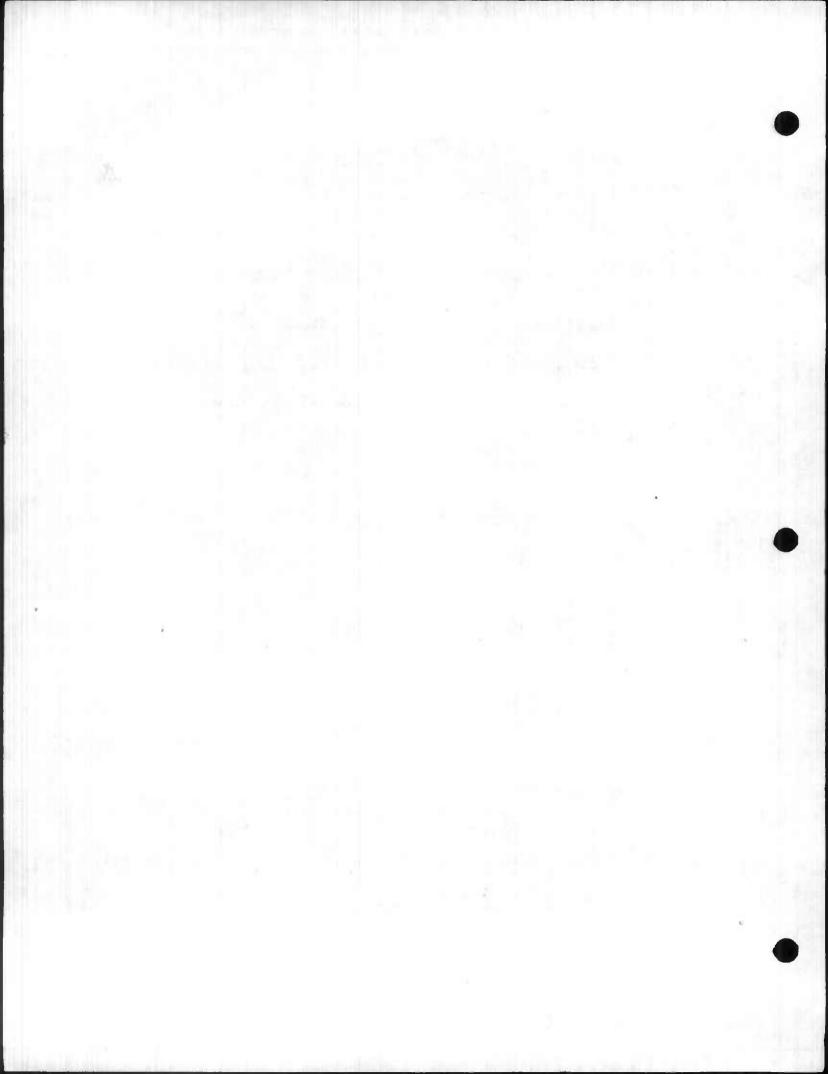
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** JANUARY 19,2000 12:10P.M /Medical Leonard P. Borotka 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 12 M 2 ☐ F Birthplece (State or Foreign Country) **Funeral** Months Deys 213-30-0922 Director June 29, 1932 Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flame 23a or 28a-f show the Medical Examiner must be notified at 1) Yes 2□No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 East Lee Street, Suite 1009 21202 USA 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 D Yes 2 DNo
If Yes, Give
Year or Dates: 1951-54 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementery/Secondary (0-12) College (1-4or 5+) 5+ Self-employed Attorney 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) B Leonty Borotka Mary Zadroga 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mary Davis/Sister 10 East Lee Street, Suite 1009 Baltimore, MD 21202 Baitimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/20/00 Baltimore, MD 21. Signature of Funeral Service License 22. Nama and Address of Fecility Thomas Gregor Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ratio men physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. noch Due to (or es a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vitai 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P s effer death. I Director: Affart od in by the funer Aftar 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end mennar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Matilda H. So, up 1/19/2000 D26250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHARLES ST., BALTIMORE, MD. 21204 GBMC MATILDA 31. Date tiled (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

32. Registrar's Signeture

JAN 2 1 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year Rev. Pope Furman Brock, Jr. 16, 2000 10:07 AM JANUARY 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth Month, Dey, Year May 21, 1922 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Macon, Georgia 1⊠M 2□ F 260-34-6126 77 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limita 1 Yas 2XI No Maryland Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6011 Hunt Ridge Road #3122 21210 United States of America Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Evar in U.S. Armed Forcas? 14. Raca - American Indian, Black, Whita, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Episcopal Priest Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pope Furman Brock, Sr. Alice Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Amelia L. (nee Sentz)Brock (Wife) 6011 Hunt Ridge Road #3122 Cockeysville, Md. 21210 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 Cramation 3 ☐ Removal from State Hilltop Service Corporation 01/18/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) sature of Funeral Service Lipensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Part Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE disease or condition resulting in death) Due to (or as a consequenca of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner Examiner that the death certificate be executed physician and as the burial-trans Box 68760, Physician/Medical P.O. 2 been signed t should be det Records, by Completed page 2 certificate Division of Vital al or Attending Physician: T s after death. Il Director: After this certificat of in by the funeral director, p Be Certification: To 124 hours a Hospital Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Nerns 23a or

natural, or

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traumatic event pools.

Physician /Medical

hours after

filed within Hygiene.

Baltimore, Maryland 21215-0020

Directo

Funeral

ğ

Completed

Be

2

25. Was case referred to medical axaminar? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending Invastigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

🔀 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License numbe

29b. Signati

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFONSO ZALDUONDO M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

2000

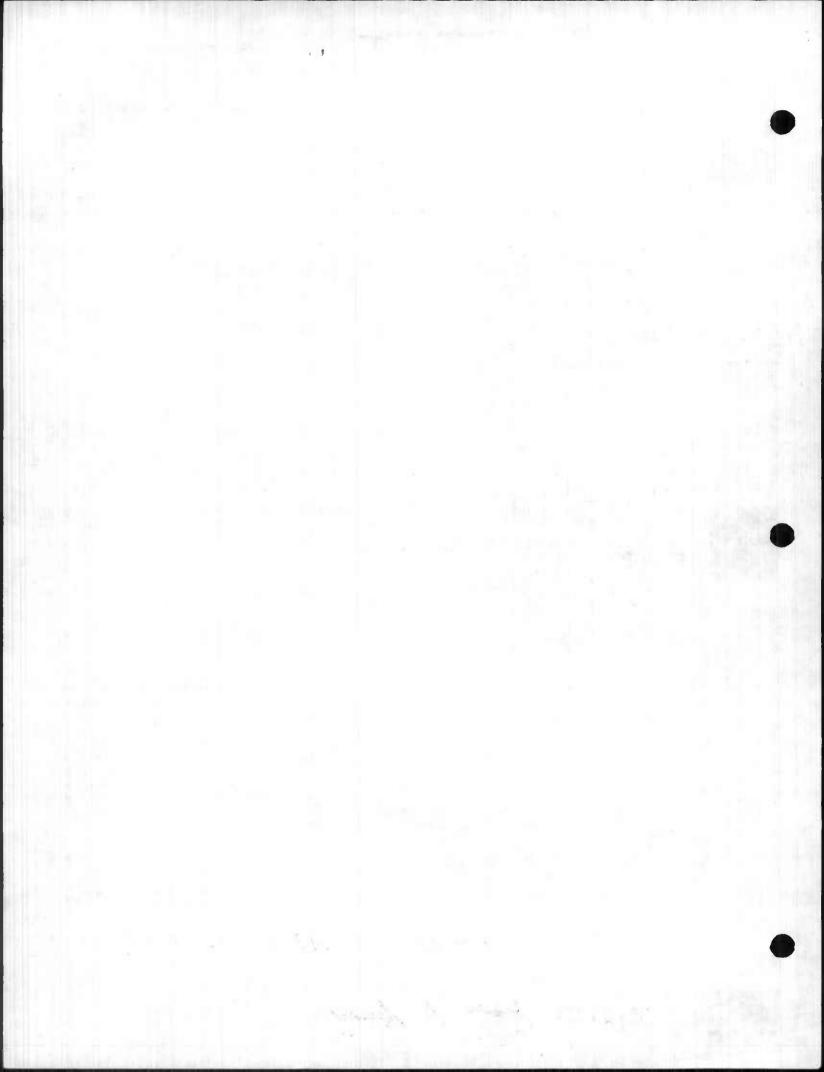
32. Registrar's Signature

State Registrar

tely

within 2 To the Complet

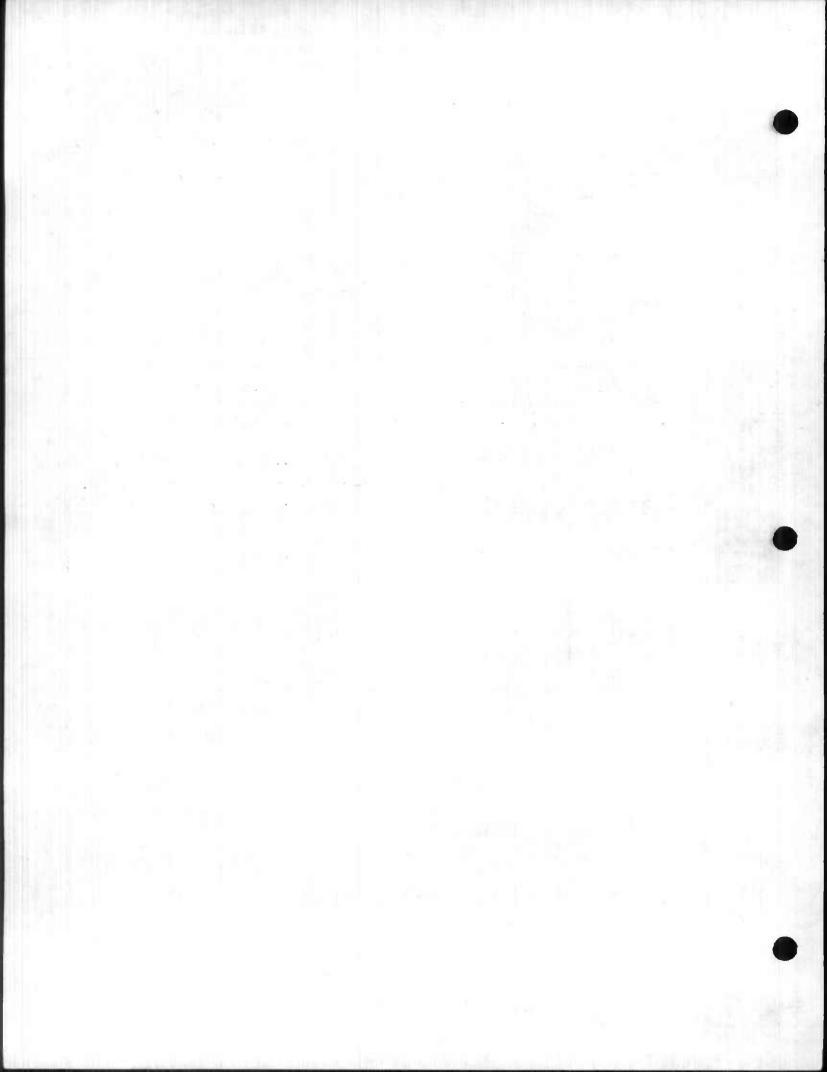
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner	Decedent's Neme (First, Mid	, Last/							2. Dete of	~ PUH!			3. Time of Death
miner			Jeane	tte B.	Bear	man			Month	Da ary 1		Year	12:07 F
	4a Facility Neme (If not institut	on, <i>giv</i> e si	treet and nu	imber)				4b. City, Town, or I	ocation of De		County		
	Gilchrist Cen	ter						Towso	n ore Co.	. F	Balti	more	CO
	5. Social Security Number	6. Sex		7. Age (In y	rs. last birth	day) If Und	der 1 Year	If Under 24 Hrs. Hours Min.	9 Date of I	Birth Day, Year)			place (Steta or Forei
	412-34-9611	10	M 2⊠F	73	Yr	S.	lo Duys	Tiodis IMIII.	March				nessee
	Usuel Residence of Decedent 10s. State 10b. Coun	v		10c	City, Town o	or Location						1	0d. Inside City Limi
2	Maryland	•	ford	100.	Ony, Town	DI EDUATION	Jop	na					1 Yes 2 A
Director	10e, Street and Number	IIai	LIOLU			106	Zip Code	pa		10a Cit	tizen of W	het Cour	
						101.		01.005					
Funeral	1309 Winding			.Ve sedent Ever in	nUS	13 Wes De		21085 Hispanic Origin? (S	pecify Yes or		14. Rece		tes an Indian,
Dy run	1 Never Married 2 Never Marri	med	Armed From 1 Yes, Gir Year or D	orces? 2⊠ No ive			pecify Cub	Hispanic Origin? (Sen, Mexican, Puert Specify:	o Rican, etc.)			c, White,	
	15. Decede	nt's Educ	ation		16a. D	ecedent's U	suel Occup	pation		16b. K	and of Bu	siness/Inc	dustry
į	(Specify only high Elementary/Secondary (0-12)	est grade	completed) College ((6	Give kind of ite. DO NOT	work done use retire	pation during most of world)	king				County
Completed	12 Years		Control (1-401-347	S	ecreta	arv			Pu	blic	Sch	ools
Be C	17. Father's Name (First, Middle	, Last)						18. Mother's Nan	na (First, Midd	tle, Maiden	Sumamo	9)	
10 E	Harvey Bridg	es						Bes	sie G1	andon	1		
	19e. Informent's Neme/Ralation	ship (Typ	oe, Print) (Husbar	nd) 19b. N	Aaiting Addra	ass (Street	end Number or Ru	ıral Route Nur	nber, City o	or Town,	Stata, Zip	Code)
	Mr. George Be	armar	ı, Jr.					g Valley	Drive		oa, M		
	20a. Method of Disposition 1 □ Buriai 2 □ Cremetion 4 □ Donation / S Other			Stete		cremetory o	or other ple	ce) 1 Gdns.1/	Dete / 21/00				own, Stete Maryland
	21. Signeture of Funeral Service		-		Z	22. Name Duda	end Addre	ess of Fecility k Funeral	Home	of Du	ındal	k, I	nc.
_	23a. Pert1. Enter the stresse, shock, or heart failure. Li	or complic	ations thet	caused the d	eath. Do no	t enter the m	2 Wis	e Ave. Du	or respireton	Mary arrest,	land	21	222 Approximete Intervel Between
Je	immediata Causa (Final disease or condition resulting in death)	е.		1		,		einou			HT.	1	Onset end Death 2 month
a Evalune	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	5 b.		Due to	o (or as a co	nsequence o	of):	15				1 t	
STAMPOICE	thet initiated events resulting in death) Last	l d.		Due to	o (or as a cor	nsequence o	of):					1	
2	Part II. Other significant condi-	ions conti	ributing to d	leath but not	resulting in t	he underlyin	g cause gi	ven in Pert I.	23b. D	ld tobacco	use con	tribute to	o the cause of deat
by Physician/Me									1	□ Yee 2	No No	3 Pro	bebly 4 ☐ Unkno
Completed						-				es an auto rrormed?	ppsy	av	ere autopsy finding railable prior to empletion of cause daath?
E									11	☐ Yes 2	No	1[☐Yes 2☐No
BeC	25. Was case referred to medic	ai						28. Place of Dea		,			
Certification: To B	examiner? 1 Yes 2 235No 27. Manner of Death 1 Manual 5 Penc	ing	28a. Dete		2 ER/Outp 28b. Tin Inju	ne of	28c. Inju	her: 4 Nursing H ny at nk? 1 Yes 2 No	lome 5 Re 28d. Descrit		6 MOthe		mHospia
DI HILLAND	3 Suicide 6 Coul	tigation I not be mined	28e. Place build	e of Injury - A ling, etc. (Spe	t homa, fam ecify)			1163 2010	28f. Location City or	n (Street a Town, Stet	nd Numbe	er or Rure	el Route Number,
edicai c			er: On the b					ma, data and place opinion, daath occu					
Me	29b. Signature and title of certif	ier	1	0		:	29c. Licen	se number		29d. Da	ate signed	(Month,	Day, Year)
	Al And	Con	1/4	-	mo		025	5205		Jan	1019	141	8 2000
	30. Name and address of perso W.A.Riley	/ /	npleted cause	6 70 1		ype, Print)	(es . C	t. Bali	lo. n	nd 2	(70	4	-,

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 5:30 AM JAN. 19, Fannie Lou Burkey 2000 4e. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth | Laurel | P | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 191 Prince Georges Cherry Lane Nursing Home 6. Sex 1 ☐ M 2 ☑ F 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) 223-30-4740 Yrs. 83 MAY 10, 1916 Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9001 Cherry Lane 20708 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Halard Handy Fannie Lou Porter 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Frances Jane Tate - daughter 9080 Moonshine Hollow #M, Laurel, Md. 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1/21/00 1 Description 3 Removed from State Meadowridge Memorial Park Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of E aral Service License 22. Name end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 elles and Intel the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heer failure/ List only one ceuse on each line. Approximate Interval Betw Immediete Cause (Finel diseese or condition resulting in death) 3 weeks PNEUMONIA Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or es a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one)

Physician /Medical **Examiner**

permit. Page Department of Important: If eny Injury or once.

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

Funeral

p

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryla neat of Health and Mantal Hygiens. It is the marked other than "natural", or florm 23a or 28a-f shown if florm 27 is marked other than "natural", or florm a 23a or 28a-f shown into or other traumatic avent, it a Madesa Evarrate must be nutified at

Baltimore, Maryland 21215-0020

the Maryland

sician and burial-transit physician s the buria signed by the etta plnods page 2 funeral director, After

The law requires that the daath certificeta be executed

Hospital or Attanding Physician:

24 hours after death.

To the To the Complete

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be pletely filled in by

State Registrar

Certification: To

edical

Hospital: 1 ☐ Yes 2 No 5 Pending investigation

6 Could not be determined

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

28e. Dete of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Tyes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

29c. License number 00 8307 29d. Date signed (Month, Dey, Year)

3450 Fort Meade Rd Laurel MD 20724

31. Date filed (Month, Dey, Year) __

TAKY

29b. Signeture and the strentilies

27. Menner of Death

1 Naturel

3 Suicide

29a. Certifier

2 Accident

4 Homicide

32. Registra & Signature

MOURTZANAKUS

end manner stated.

Sunu >

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s)

DHMH 16 Rev 6/95



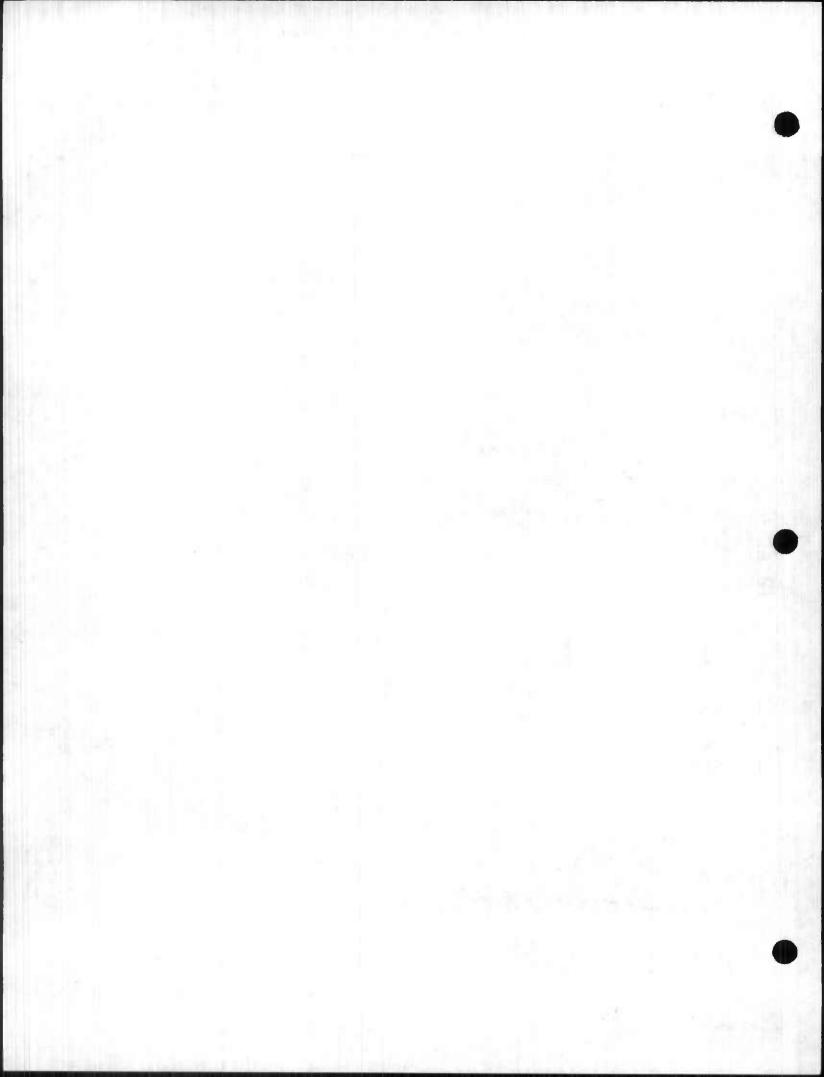
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

-	0	0	0	1 1
	0	U	3	1 -

				Certificate	of Death		Reg. No.	0 01011	
	1. Decedent's Name (First, Middle, La	st)				2. Date of De		3. Time of Death	
sician ledical	Howard Carl Bee	elen , Sr.				Januar	ry 97, 2	000 10:45 p.n	1.
iner	4e Facility Name (If not institution, giv	e street and number)			4b. City, Towr	n, or Location of Deat	4c. County	of Death	
	13221 East Green	oank Road			Middle			imore	
	219-05-9889	TYM OF E	(In yrs. last bir	hdey) If Under Months		Min. 8. Date of Bir (Month, Da July 10	th y, Year) 5, 1922	9. Birthplace (State or Foreig Country) Maryland	חן
	Usual Residence of Decedent 10a. Stete 10b. County	1	Oc. City, Town	or Location				10d. fnside City Limit	S
Director	Maryland Baltimon	re	Middl	le River			10-00	1 ☐ Yes 200 N	
rai Din	13221 East Green	oank Road		10f. Zip	1220		U.S.A.	vnat Country?	
by Funeral	11, Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? MXYes 2 No If Yes, Give Yeer or Dates:		13. Was Deced If Yes, speci 1 Yes 2	ify Cuben, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		e - American Indian, k, White, etc. White	
ted	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's Usua	Occupation	of working	16b. Kind of Bu	siness/Industry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			k done during most of e retired)	Working	Mack Tr	nok	
	8		Tri	uck Mecha		Nome (First Middle			
Be	17. Father's Name (First, Middle, Last,				18. Mothers	s Name <i>(First, Middle</i> na Hanth	, Meigen Sumam	0)	
9	Harry Beelen		1	Adams A A A A	1.0		Oh. T	Crete Zin Codes	
	19a. Informant's Neme/Relationship (or Rural Route Numb		e, Maryland 21.	221
	Dorothy Beelen (wite)	20h Place of	Disposition (Nam	ie of	Dete Dete		City or Town, Stata	
	1 28 Burial 2 Cremation 3 C		cameter	y, crematory or of cod Ceme:	ther placa)			ore, Maryland	
n/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c	ne to (or as e	consequence of): consequence of): consequence of):	ial lun	fibro g dire	asc		
icia	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ca	ause given in Part I.	23b. Did	tobacco use co	ntribute to the cause of desti	h?
y Physician/	Coronay	artery				10	Y00 2 00	3 Probably 4 Unkno	wn
Completed by						24a. Was perf	an autopsy omed?	24b. Were eutopsy findings available prior to completion of cause of death?	
HO						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
BeC	25. Was case referred to medical				26. Place of	of Death (Check only			
To B	exeminer? 1 ☐ Yes 2 M No	Hospital:	2 🗆 ER/Ou	tpatient 3 DO	Other: 4 Nurs	sing Home 5 Res	idenca 8 🗆 Oth	er (Specify)	
on: 1	27. Menner of Death	28a. Date of Injury (Month, Day)	28b.	Time of 2	8c. Injury at Work?	28d. Describe	how injury occur		
Certification:	2 Accident Investigatio 3 Suicide 6 Could not be determined	e 290 Place of faire	y - At home, fa (Specify)	m, street, factory		28f. Location	(Street end Numb wn, State)	per or Rural Route Number,	
edicai C	29a. Certifier (Check only one)	nyafcian: To the best of entire: On the basis of eand manner stete	xaminetion an	, deeth occurred a d/or investigation,	at the time, date and in my opinion, death	place, and due to the occurred at the time	cause(s) end mi , date and place,	enner as stated. and due to the cause(s)	
Me	29b. Signature and title of certifier	0 1		290	. License number		29d. Dete signe	d (Month, Day, Year)	
	▶ Naomi 8	. Coller	no		8272	20	1/1	9/00	
	30. Nama and address of person who NAOm; P. Cui.	completed cause of dea	th (Item, 23a),	(Type Print)	Health (8	enter !	792 m	court Bld	
ate	31. Date filed (Month, Day, Year)	32. Regisfrar	's Signature	4 1	sa la	-		1 1 2 3 10 3)

DHMH 16 Rev 6/95



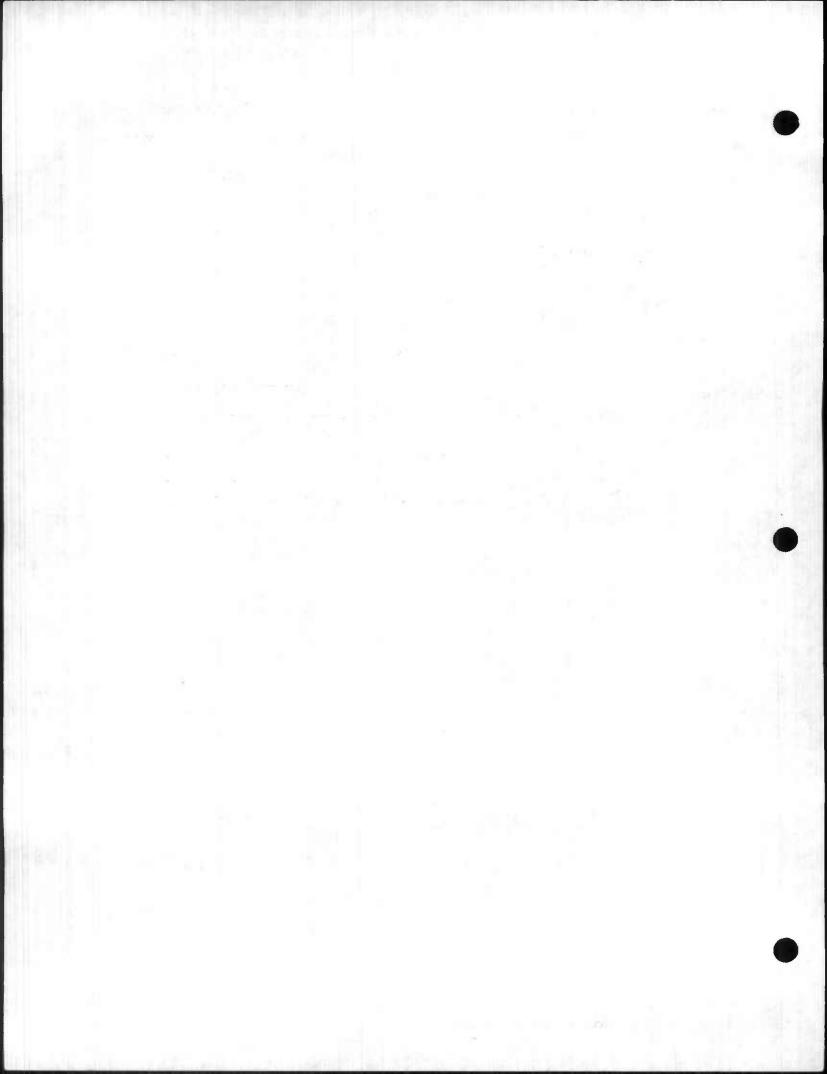
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Stephen J. Borcik 20, 2000 11:00AM January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 402 Cockeysmill Road BAltimore Reisterstown 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Sex M M 2 F 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours Yrs. 189-12-7862 74 Director PA Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. inside City Limits or harns 23e or 28e-f show the Manyle the Medical Examiner must be notified at MD Baltimore Reisterstown 1 ☐ Yes 2 No Directo 10e. Sfreef and Number 10f. Zip Coda 10g. Citizen of What Country? 402 Cockeysmill Road 21136 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Detes: WW I I 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Sfafus should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify py 3 ☐\Widowed 4 ☐ Divorced WWII White Completed f5. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 4 Accountant Accounting 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Mental Stephen Borcik Barbara Bachich n g 19e. Informanf's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Pages 1 and 2 402 Cockeysmill Road, Reisterstown, MD Jon R. Borcik nt of Health : If them 27 b Baltimore, 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlai 2 ☐ Cramation 3 ☐ Removal from Stafe ò Calvary Cemetery Pittsburgh, PA 4 ☐ Donafion 5 ☐ Other (Specify) 22. Name end Address of Facility any in 11824 Reisterstown Rd 21136 Eline Funeral Home Reisterstown, MD complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one cause on each line. Approximete intarval Between Onset and Death 23e. Part 1. Enter the blues shock, or hair 1 huma **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical MOS Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trans Sequentially list conditions, it any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last pue Due to (or as a consequence of) P.O. Box 68760, attending physiclan Due to (or as a consequence of): be detached Part II. Other eignificant conditions confributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown of Vital Records, Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was an autopsy performed? director, page 2 should After this certificate has been 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Dete of Injury (Month, Day Year) Director: After this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier completely 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signatura and fitte of certifier 120/00 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) CHARLES ST. BATIMULE, MO 21204 COLIEN 6569 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day January 15, 2000 Brandon 4:30am Bernice 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sax Birthplace (State or Foreign Country) Hours Months 10 M 200 062-22-4575 88 Yrs. April 16, 1911 Usual Rasidance of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits **Baltimore** n/a 1XX as 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3716 Nortonia Road 21216 USA Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yas 2 ☐ XXXX If Yea, Giva 1 □ Yaa 2 □ No. Specify. Specify: Black 3 Widowed 4 □ Divorced Yaar or Datas 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City 4+Collega (1-4or 5+) Elementary/Secondary (0-12) Educator Dept. of Education 17. Fathar'a Nama (First, Middle, Last) John H. Bias 18. Mother's Nama (First, Middle, Malden Surname) Francis Lane 19a. Informant's Name/Ralationship (Type, Print) Peggy Brandon Brown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Nortonia Road Baltimore, Md. 21216 Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Deprial 2 Cramation 3 Removel from Stete Laurel, Md. Md. National Mem. Park Jan.20 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 ulle 23a. Pert1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximeta Intarval Between Onset and Death Immediata Cause (Finel disaasa or condition rasulting in daath) Sequentially list conditiona, if any, leading to immadiate cause. Enter Underlying Cause (Disaese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an eutopay performed? 1 Yaa 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 5 Pending Invastigation 1 Natural

The law requires that the death certificate be executed burial-transit P.O. Box 68760. the been signed by the atte should be detached for Division of Vital Records, or Attending Physician: After this funeral

Physician/Medical Completed by Be Medical Certification: To

Physician

/Medical

Examiner

Md.

Director

Funeral

þ

Completed

89

Funeral

Director

28a-t

must be r

permit. Pages 1 and 2 ahould be filled within 72 hours aher. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or lie any injury or other traumatic event, the Medical Examine

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

24 hours after death.

Funeral Director: Al filled in by Hospital

within 24 hor To the Fune completely fi

ŝ

Registrar

29b. Signatura and titla of certifie

2. Accident

4 Homlcide

(Check only one)

3 Suiclda

29e. Certifier

29c. License number 1275

28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

CAPETHA RAJA , 4367 Holling A ,4367

Bult, MD -21227

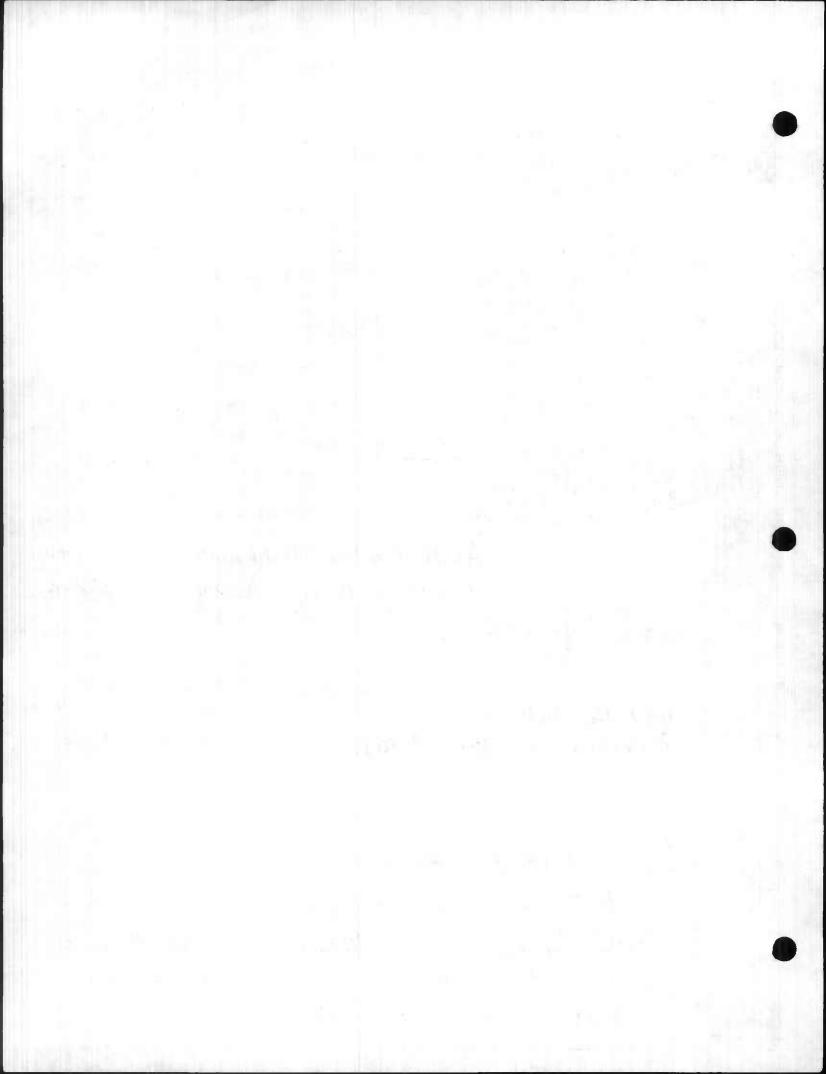
1 ☐ Yes 2 ☐ No

31. Data filed (Month, Day, Year)

JAN 2 1

6 Could not be determined

32. Registraria Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Elizabeth K. Balmos 16, 2000 4:15PM Jan. /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. Hours Min. If Under 1 Yeer Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1 M 2 DF Yrs. 212-30-3609 67 Dec. 14,1932 Perry Hall, MD. Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limite 1 ☐ Yes 2 No Directo 28a-f Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 430 Mirabile Lane 21224 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Detes: 14. Race - American Indian, 11 Merital Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married Specify: White 'natural', or 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Homemaker n/a Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be 2 and Mental 2 William Thomas Kahl Margaret Helen Eurice 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) M's Margaret B. Pfarr 1327 Jervis Square Belcamp, MD. 21017 riportant: If Item 27 20b. Place of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Pages ŝ 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1/18/2000 Baltimore, MD. 22. Name and Addrass of Facility 21. Signatura of Funeral Sarvice Line E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, MD 21087 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the disease, or complications that caused the death. shock, or haart failure. List only one cause on each ling. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Iva to 00 diseese or condition resulting In deeth) Examiner will Examiner monia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 9 Vitai Records, þ 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? Completed Salmos, Elizabeth completion of cause of death? 1 ☐ Yes 2 ☐ No (agetes 25. Was case referred to medical exeminer? 86 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 1- Neturel 5 Pending investigation 1 Yes 2 No after death. 2 Accident Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral Completely filled edical 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signetura and title of purtifug 29d. Date signed (Month, Day, Year) ACF 30. Nama and addrass of person who completed cause of daeth (ttem 23a) (Type, Print) Edgewood MO 21040 Busines 1308 Lolresti 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 1 2000 Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Year **Physician** W. COPSEY JOSEPH 21 JANUARY 2000 01:51 A.M. /Medical 4a Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) TOWSON If Under 24 Hrs. BALTIMORE Birthplace (Stele or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days 10M 20F Months Hours 80 Director 219-16-6420 NW, 2, AK MD Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Director 1 Yes 2 No 28a-f MD PARKVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT : E ò USA 14. Raca - American Indien, 21234 Funeral 2908 KINGS RIDGE 20 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married ĕ 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 H.S. CROCKER LITHO LITHOGERAPHY 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be and 2 should be saith and Mental UNKNOWN PUTH BOWLES 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) . or other tra Health ALICE COPSEY 2909 PARKULE, MD. 213 te | 20c. Location - City or Town, State SPOUSE RIDGE ED. KINGS MD. 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 8 JAN 24, 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) PARKWOOD CEMETERY 2000 PARKVILLE MD 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility EVANS FUNERAL CHAPEL SSOO HARFORD RD. PARKVILLE, MD. 21234 allors thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, ause on each line. Approximeta tritervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel FAIL URIS disease or condition resulting in death) Examiner Due to (or as a cons Examiner w. sician and burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of): Physician/Medicai Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed NG CANCES page 2 certificate 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation After Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 3 Suiclde 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai

Registrar

10755 31. Date filed (Month, Dey, Year) State JAN 2 1 2000

(Check only one)

29b. Signeture and title of certifie

C

FAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOAD SUITE 32. Registrer's Signeture

29c. License number

29d. Dete signed (Month, Day, Year)

· LUTHERVILLE MD 21093

I

W

0

141

176 12

ahe.

21215-0020

Baltimore, Maryland

Pages 1

The law requires that the death certificate be assecuted

Box 68760,

Division of Vitai Records, P.O.

or Attending Physician:

Hospital

within 2 the the

that he was a series of the control of the A COMPANY OF THE STATE OF THE S HOWARD COKER

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD REED COKER, SR.

621 NORTH HIGHLAND AVENUE

4a Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

14, 2000

4c. County of Death

Month JAN.

4b. City, Town, or Location of Death

BALTIMORE

3. Time of Death

1922 PM

MD. N/A BALTIMORE 106. Stream and Number 106. 21 N. HIGHLAND AVE. 115. Martial Status 110 Nover Martind 110 Nover Martind 110 Nover Martind 110 Nover Martind 111 Martial Status 111 Nover Decedent of Highland (Opin)* (Speadly Yea or Nover Martind 111 Nover Decedent of Highland (Opin)* (Speadly Yea or November Advanced or November (Opin)* (Speadly Yea o	uneral irector	L	577-32-		1 ∑ M 2□F	72	Yrs	Months	Days	Hours	Min. AU	G. 27	, 192	7 Country,	MD.
Elementery/Secondary (0-12) College (1-4or 5+) MECHANIC REFRIGERATION	B m			1		10c.	. City, Town o	Location		-				10d.	Inside City Limits
Elementery	to to		MD.	N/2	A		BALTI	MORE						18	XXYes 2□No
Securities Sec	rec inch	1	0e. Street and Nu	umber				10f. Zip	Code			100	. Citizen of V	Vhat Country	?
Elementary/Gacondary (0-12) UNK. 17. Fathar's Name (First, Micklet, Macken Summan) UNK. 18. Informant's Name/Pelationship (Type, Print) ELIZABETH COKER/WIFE 20a. Method of Disposition 19 Divide 2 Informant's Name (Pirst, Micklet, Macken Summan) 20b. Place of Disposition Name of Place of Number or Place of Disposition Name of Careful Number or Place of Number or Place of Number or Place of Number or Place of Disposition Number or Place of Number or Place of Disposition Number or Place of Number or Place of Number or Place of Disposition Number or Place of Number or Place of Disposition Number or Place of Disposition Number or	300		621 N.	. HIGHLA	AND AVE				21	205			USA		
UNK. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Informant's Name/Relationship (Type, Print) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) 20c. Location, City or Town, State) 20c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number) 21b. Mailing Address (Street and Number or Rural Route Number) 21c. Supplied For Town, State) 22c. Location, City or T	or, or hams 2	1	1 Never Mar	**	Armed Fo	rces?		if Yes, spec	cify Cub	an, Mexican	gin? (Specify i, Puarto Rica	Yes or No- n, etc.)	Blac	ck, White, etc	
UNK. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 10	n "natural			ecify only highest g	rade completed)	l dos Su)	10	ive kind of wor	rk done	dunina most	t of working	16	6b. Kind of Bu	usiness/Indus	try
UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Paula Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 Other (Seption) 10 Burlat 2 Chemistro 3 Removal from State 4 Docation 5 Children (Seption) 10 Burlat 2 Chemistro 3 Removal from State 4 Docation 5 Children (Seption) 10 Burlat 2 Chemistro 3 Removal from State 4 Docation 5 Children (Seption) 11 Burlat 2 Chemistro 3 Removal from State 12 Description 6 Children (Seption) 13 Septimized Funeral Service Moreon and Printing Service Mor	E E				College (1-401 3+)	1	MECHAN	IIC			1	REFRI	GERAT	ION
ELIZABETH COKER/WIFE 20a	Y -				st)							st, Middle, Ma	aiden Sumam	10)	
ELIZABETH COKER/WIFE 20a			19a. Informant's N	Name/Relationship	(Type, Print)		19b. M	ailing Address	(Street			ute Number, (City or Town,	State, Zip Co	ode)
CROWINSVILLE CROWING CROWING CROWINSVILLE CROWING	Tree.							_							
23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betwee Onset and Death Inte	ry or other	2	1 Burial 2	□Cremation 3		Chata	b. Placa of Di cemetery,	sposition (Nan crematory or o	ne of ther ple	ce)	D	ate 20	C. Location -	City or Town	, State
Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) Immediate Cause (Final disease or condition rasulting in death) If any, leading to immediate Cause (Final disease or linury that imitated events resulting in death) Immediate Cause (Final disease or condition rasulting in death) If any, leading to immediate Cause (Final disease or linury that imitated events resulting in death) Immediate Cause (Final disease or conditions conditions conditions or consequence of): If any, leading to immediate cause (Final disease or linury that imitated events resulting in death) Immediate Cause (Final disease or conditions conditions conditions conditions conditions) If any, leading to immediate cause (Final disease or linury that on the cause of the cause o	eny in		23a, Part1, Entar	the disease, or co	mplications that of	aused tha d	MUSAI Jaath. Do not	CHARL 6224	ES EAS	S. Z	EILER AVE.	, BAL	TIMOR	E, MD	pproximate
24a. Was an autopsy performed? INSPECTION	dical	1	tisease or conditi	ion	a Arter				ovas	cular	Disea	se			nset and Death
24a. Was an autopsy performed? INSPECTION Yes 2 No	Examin	1	Sequentially list of any, leading to it sause. Enter Und	conditions, immediate derlying	b	Due t	o (or as a con	sequenca of):							
24a. Was an autopsy performed? INSPECTION I yes 2XNo I yes 2 No 25. Was case referred to medical examiner? XY es 2 No 26. Place of Death (Check only one) 27. Manner of Death XNeturel 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural Route Number of Town, State)	se as the bu	1	Cause (Disease o hat initiated even esulting In death)	or Injury ts) Last	c	Due to	o (or as a con	sequenca of):							
24a. Was an autopsy performed? INSPECTION	by the ener tached for u	F	art it. Other sign	ificant conditions	contributing to de	eath but not	resulting in th	e underlying c	ausa gi	ven in Part I					
This per to medical	ed by	-	Vig. 1s											availe	ble prior to
25. Was case referred to medical examiner? XXYes 2 No 25. Was case referred to medical examiner? XXYes 2 No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death XXNeturel 5 Pending investigation 2 No	has ge 2	-		4								INSPEC	TION	of dea	ath?
2 Nursing Homa SXX asidance 6 Other (Specify)	tor, p			erred to medical						26. Place	of Death (CI				
27. Manner of Death XXNeture 5 Pending investigation investigation 2 Accident 4 Homicide 4	direc] No	Hospital:	inpatient	2 ER/Outpa	tient 3 DC	OA Oth	oer:				er (Specify)	
3 Suicide 4 Homicide 28e. Placa of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural Route Number City or Town, State) 29e. Cartifier (Check In Suicide 4 Homicide 28e. Placa of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural Route Number City or Town, State)		2	7. Manner of Dea	ath 5 Pending		of Injury th, Dey Yea	r) 28b. Tim Inju			ry at	28d.				
29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	od in by the Certific			dotormino	4 200. PIRCE	of Injury - / ng, etc. (Sp	At home, farm ecify)	street, factory	, offica					per or Rural R	loute Number,
and manner stated.	pletaly fille edical (2		1☐ Certifying F	miner: On the bi	asis of exan	knowledge, d nination and/o	eath occurred Investigation,	et the ti	me, date an opinion, dea	d place, and oth occurred a	tue to the cau the time, date	use(s) and ma e and place,	anner as state and due to th	ed. le cause(s)

eet and Number or Rural Route Number, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) JAN. 14, 2000 O.C.M.E 111 Penn Street, Baltimore, Maryland 21201

State Registrar

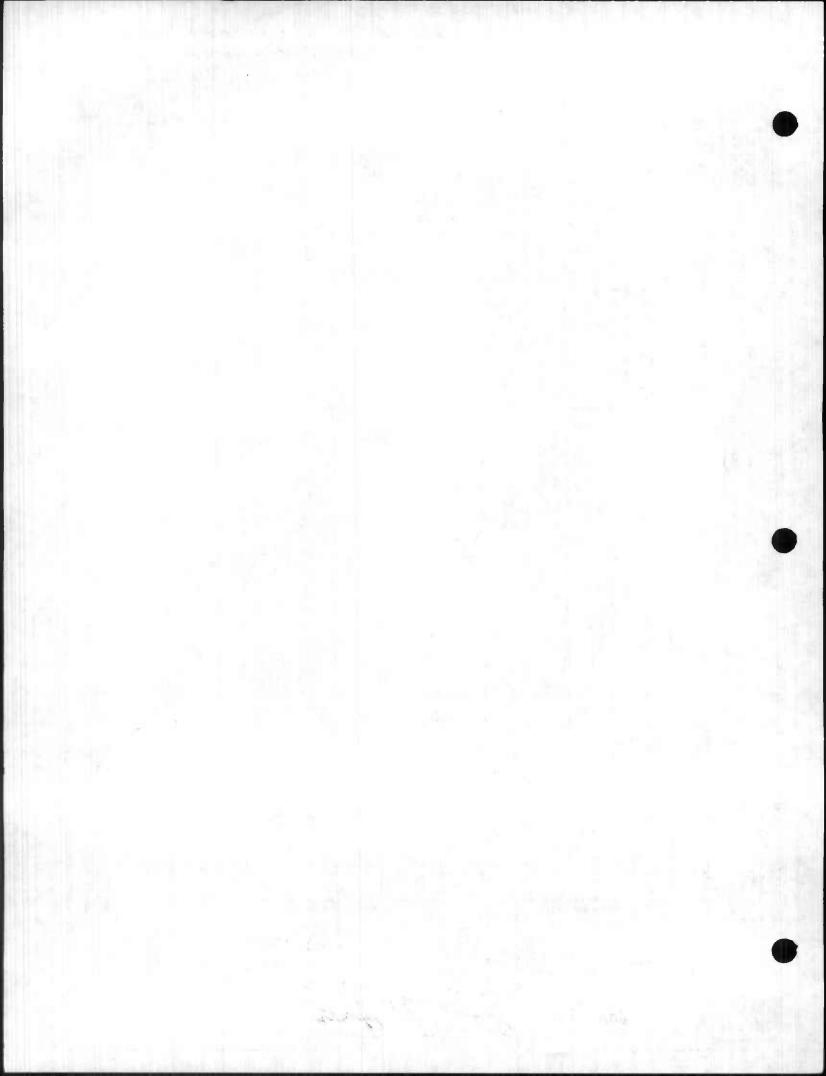
31. Date filed (Month,

2

DHMH 16 Rev 6/95

d cause of death (item 23a) (Type, Print)

32. Registrar's Signature

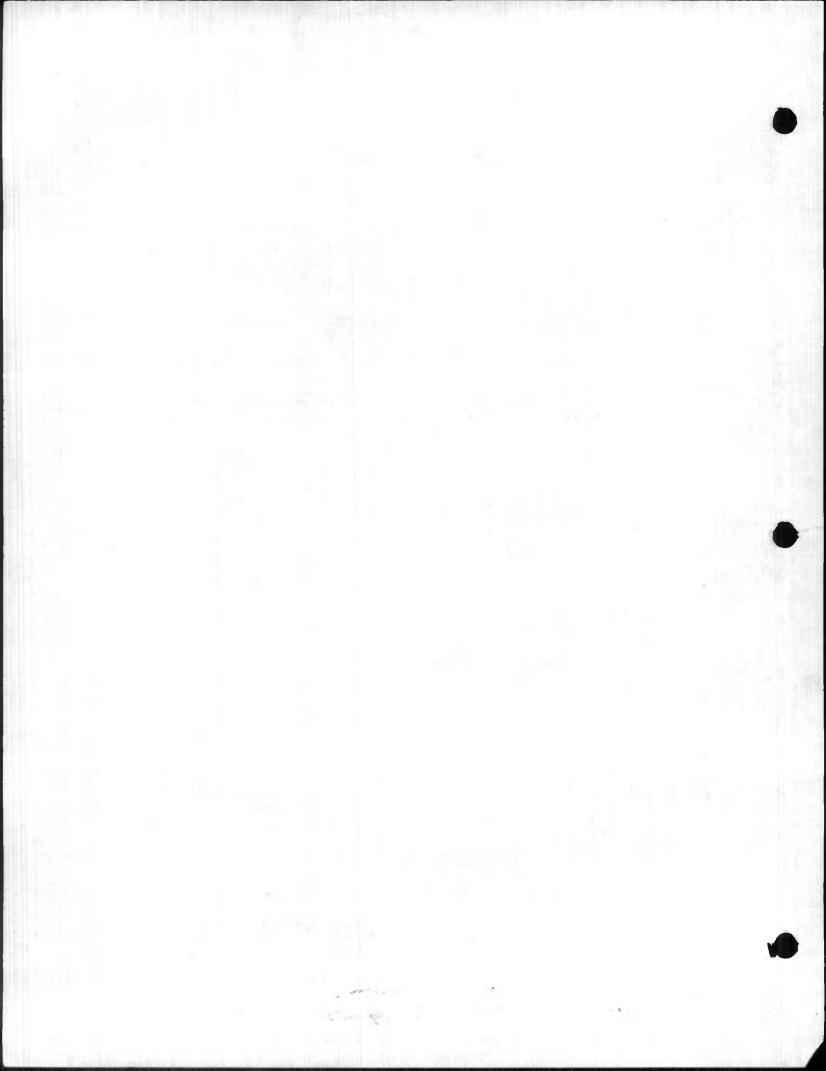


Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

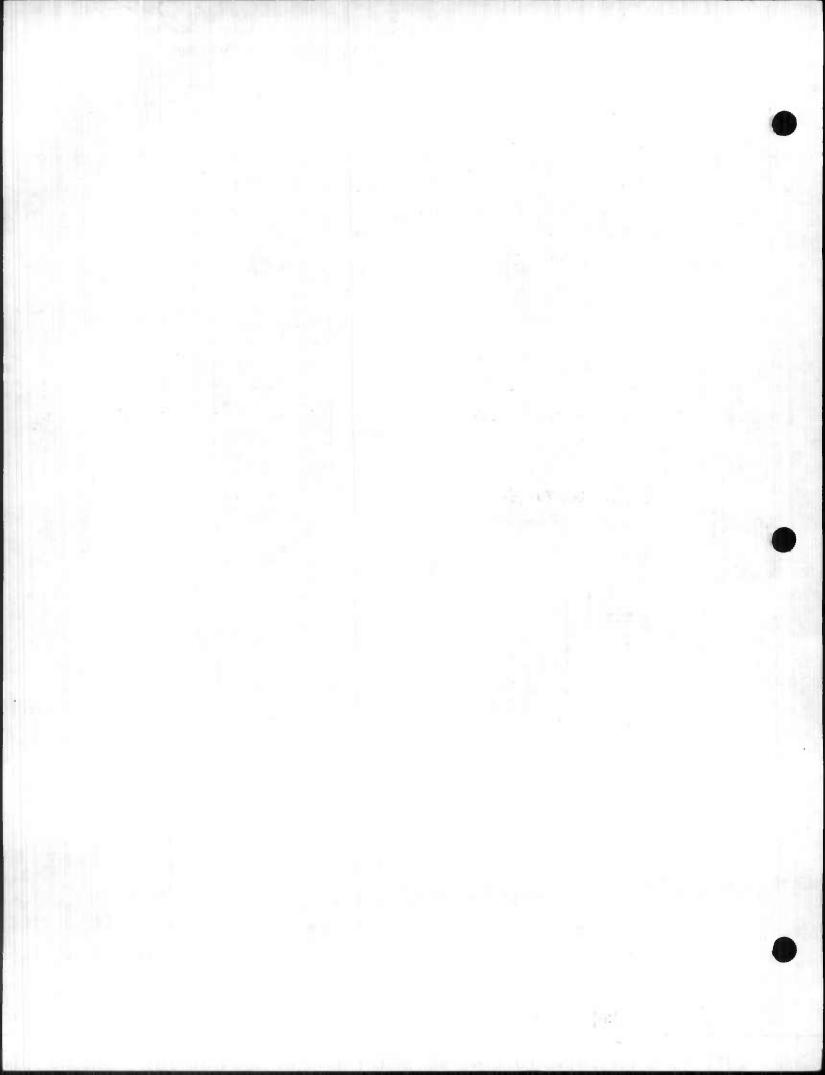
	Decedent's Neme (First, Middle, Le	ist)	Cei	rtificate of	Death	2. Data of Deat		3. Time of Deeth
Physician /Medical	MILDRED P. C	ROCKETT				JAN. 1	7, Dey 2000	2:05PM
Examiner	4a Facility Name (If not institution, given RIVERVIEW NURS				4b. City, Town, or L ESSEX	ocation of Death	4c. County of I	Death IMORE
Funeral Director		Sex 7. Age (In X 89	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, APR . 22	Year) 1910	Birthplece (State or Fore Country) VA.
No. 14	Usual Residence of Decedent 10a. Stete 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Lim
be notified Director		IMORE	DUNDALK					1 Yasx2x
unithen	7417 STRATTON	WAY		10f. Zip Code 2122	22	1	0g. Citizen of Wha	t Country?
af, or items 23s Examiner must by Funeral	11. Meritel Stetus 1 Never Married 2 Merried 3 Novidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yas, Give X Year or Dates:		Was Decedent of H I Yes, specify Cub I ☐ Yes 2☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yas or No- Pican, etc.)	Bleck, V	Amarican Indian, White, etc.
ygiene. Ner than "neturn t, the Medical. Completed	15. Decedent's E (Specify only highest gr. Elemantary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	lent's Usuel Occup kind of work done DO NOT use retired IEMAKER	during most of work	king	16b. Kind of Busin	
d other event, I	17. Father's Nema (First, Middle, Last)	HOP	IEMAKEK	18. Mother's Nem	e (First, Middle, I		JME
Menta ente ev estic ev	UKN.				UKN			
7 is m traum	19a. Informent's Neme/Reletionship (DARLENE DAVIES				end Number or Ru			te, Zip Code) D • 21207
ant of mea at: If Item 2 ry or other	20e. Method of Disposition 1 XBurial 2 Cremetion 3 C 4 Donation 5 Other (Specia	Removel from Steta	Ob. Place of Dispo		ce)	Date	20c. Location - Cit	
Importa any inju	21. Signetyro of Funarel Service Lice	Seline	ki &	224 EAS	S. ZEIL STÉRN AV	E., BAI	LTIMORE	, MD. 212
ysician Medical aminer	23a. Part1. Encythe disease, or comshock, or yeart fallure. List only Immediate Causa (Finel disease or condition resulting in deeth)	Derem	,					Interval Between Onset and Deat
physician and s the burlat-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due	to (or es a conseq	uence of):				
	Ceuse (Diseese or Injury Ihel Initiated events resulting in death) Last	C. Due t	to (or es a consequ	uence of):				
d for use a	Pert II. Other aignificant conditions of	contribution to death but not	t coculting in the un	adochina nouno si	un in Dort I	22h Did to	hacco use contri	bute to the cause of de
ed by the detacher	Hyperteurie A	nterioseles			Leviar Di			Probably 48 Onk
page 2 should be detached for use a page 2 should be detached for use completed by Physician/M	Myocarbial	Infanc be a	u			24a. Wes a perform		4b. Ware autopsy findir evailable prior to completion of cause of death?
Page . page						1 🗆 Ye	98 2 No	1 ☐ Yes 2 ☐ No
eral director, page 2 s n: To Be Compil	25. Wes case referred to medical examiner? 1	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 Norsing H		e) enca 6 Other (ew injury occurred	Specify)
4 5 G	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide	e One Diese of Injury			20140	28f. Location (St City or Town	reet and Number on, Stete)	or Rural Route Number,
s and deam. If Director: After this ed in by the funeral Certification: 1				12 12 CO 15	me date and place	end due to the ca	use(s) and mann	
24 hours after deam. Funeral Director: After teley filled in by the funeral dical Certification:		nysician: To the best of my niner: On the basis of examend manner steted				red at the tima, d		
within 24 hours after deam. To the Funeral Director: Att completely filled in by the fun Medical Certificatio	(Check only 2 Medical Exar				opinion, deeth occur			due to the cause(s)
he Funeral Direct pletely filled in by	(Check only 2 Medical Example) 29b. Signature and title of certifier.	niner: On the basis of exam		restigetion, in my o	opinion, deeth occur se number	2	ate and placa, and	due to the cause(s) Aonth, Day, Year)

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, I		Certificate		2. Dete of De	Reg. No.	3. Time of Death
Physician /Medical	Georgette Ch			T	Month		000 12:05 a
Examiner	4a Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death	4c. County	of Deeth
	Charlistowa	Care Cen	ter	Year If Under 24 H	prsville	B	altimore
Funeral Director	5. Social Security Number 6. 036–05–7522 Usual Residence of Decedent	Sex 1		Days Hours M		y, Year)	9. Birthplaca (State or Foreign Country) Rhode Island
Pu A	10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
filed within 72 hours efter death with the Maryland Hygiene. Hygiene. Where than "natural", or items 23a or 28a f ahow ent, the Medical Examinar must be notified as Completed by Funeral Director.	MD Baltim	ore	Catonsville				1 □ Yes 2 ☑ No
or 2 Direction	10e. Street and Number	1,000	10f. Zip (10g. Citizen of V	What Country?
matth matth	719 Maiden Choic	te Lane 109S	212		(Specify Yes or No	U.S.A.	ee - American Indien,
'natural', or items 23a or 28a-f al idical Estamber mest be notified leted by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	If Yes, specif	nt of Hispanic Origin? ly Cuban, Mexican, Pu No Specify:	erto Rican, etc.)		ck, While, etc. White
	15. Decedent's (Specify only highest g	Education rade completed)	16a. Decedent's Usuel (Give kind of work life. DO NOT use	done during most of v	vorking	16b. Kind of Bi	usiness/Industry
d mo	Elementery/Secondary (0-12)	College (1-4or 5+)	Waitress	remedy		Drug S	tore
£ 0	17. Father's Name (First, Middle, Las	it)		18. Mother's N	leme (First, Middle,		
To B	Jeanbaptiste C	hasse, Jr.		Flore	nce Derou	in	
5	19a. Informant's Neme/Reletionship Rosemary Carpent		19b. Meiling Address (814 Willi	Street and Number or ams Street			
eny injury or other tra	20a, Method of Disposition 1 ☑ Buriat 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec	□Removel from State	Place of Disposition (Name cometery, crematory or off w Cathedral	e of ner place)	Dete 1/25/00		city or Town, State re, Maryland
eny Inju	21. Signature of Funeral Service Lic	ensee the L					omes, Inc. 1e, MD 21228
	23a. Part 1. Enter the disease, or co shock, or heart feilure. List onl	mplications that caused the dec					Approximete Interval Between
ician dical niner	Immediete Cause (Finel disease or condition resulting in death)	a. Covon. Due to	Gry Arter (or as a consequence of):	y Dise	nsl		Jear 5
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequence of):				
	Cause (Disease or injury that initieted events resulting in death) Last	Due to	(or as a consequence of):		7		
d for use a	Part II. Other significant conditions	contributing to death but not re	sulting In the underlying ca	use diven in Pert I	23b. Did 1	obacco usa co	ntribute to the cause of death:
page 2 should be detached for use Completed by Physician/M	Hypertensic				10	1	3 Probably 4 Unknow
should be belong					24a. Wes perfo	an eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
rector, page 2					101	res 2 No	1 ☐ Yes 2 No
director, page	25. Was case referred to medical			26. Place of D	Deeth (Check only o	ne)	
0 0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2[☐ ER/Outpatient 3☐ DO/	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 □Oth	er (Specify)
funera funera	27. Manner of Death 1 Netural 5 Pending investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe I	now Injury occur	red
completely filled in by the funera Medical Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be on Olean of Latina, And	home, farm, street, factory.		28f. Location (S City or Tox	Street and Numb m, Stata)	per or Rurel Route Number,
dical C	29e. Certifier (Check only one) 1 Certifying P	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred el ation and/or investigation, i	the time, date end pla n my opinion, deeth oo	ice, end due to the courred et the time,	cause(s) and me dete end place,	enner as stated. and due to the cause(s)
To the Funeral Director: completely filled in by the Medical Certificat	29b. Signature and title of certifier	and market states.	29c.	License number		29d. Date signe	d (Month, Day, Year)
'	Rober Na	lys MI)]) 5105/		Januar	4 19,2000
')	30. Nama and address of person who Av d YUS 5 G L 4 Z 31. Date filed (Month, Day, Year)	o completed cause of death (Ite	diden Choi	ce lane (ntonsvi	He, MI	95515,0
State Registrar		2000 Sener		rocks			
16 Ray 6/95	VOID N. I						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month 01 2000 William Edward Chambers 15 4a. Fecility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Cockeysville Maryland Masonic Homes If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1⊠M 2□ F Yrs. 216-09-2076 81 Aug 6, 1918 Maryland Usuei Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 300 International Circle 21030 12. Was Decedent Ever In U,S. Amed Forcas? 1 ☑ Yes 2 ☐ No if Yes, Give Yaer or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. 1 ☐ Never Married 2 ☑ Marriad 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuei Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coitege (1-4or 5+) Operator-Slab Mill 12 Stee1 n/a 17. Father's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) William Chambers Genavieve Garrigan 19e. informent's Neme/Reletionship (Type, Print) 19b. Melting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 300 International Circle, Cockeysville, MD 21030 Eleanor Chambers/Wife 20b. Piece of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 1/18/00 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility Lemmon Funeral Home Clary 10 W. Padonia Road, Timonium, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or been fallere. List only one cause on each lina. Approximete Intervel Betwe Onset end Deeth Immediate Ca. se (Fin disease or condition resulting in daath) C'hrouic Obstintine Pulnary Disease. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequance of): Due to (or es e consequance of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Probable & frontal lobe Stroke US mass 1 Yes 2 No 3K Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of causa of death? 410 Caremona of Prestate glend. 24a. Wes en autopsy 1 Yes 20KNo 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No 28c. injury et Work? 27. Menner of Death 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturet 1 Yas 2 No 2 Accident 3 Sulcide 6 Could not ba 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

Records, P.O. Box 68760 Division of Vital

Attending Physician: after death. in by tha To the Hospital or A villin 24 hours a To the Funeral C

Registrar

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

itam 27 is marked other than "natural", or hams 23a or 28a-f show other trsumatic svant, the Medical Examinar must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or ther any Injury or other traumatic svant, the Medical Exams

Physician

/Medical

Examiner

burial-transit

attending physician for usa as the buria

ata has been signed by the page 2 should be detached

certificata

Physician/Medical

Be

2

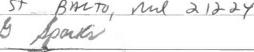
Medical Certification:

Baltimore, Maryland 21215-0020

the Maryland

ROBERT LIBERTU, MD. 3508 BANK 2 1 2000 Registrar's Signeture

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)



29c. License number

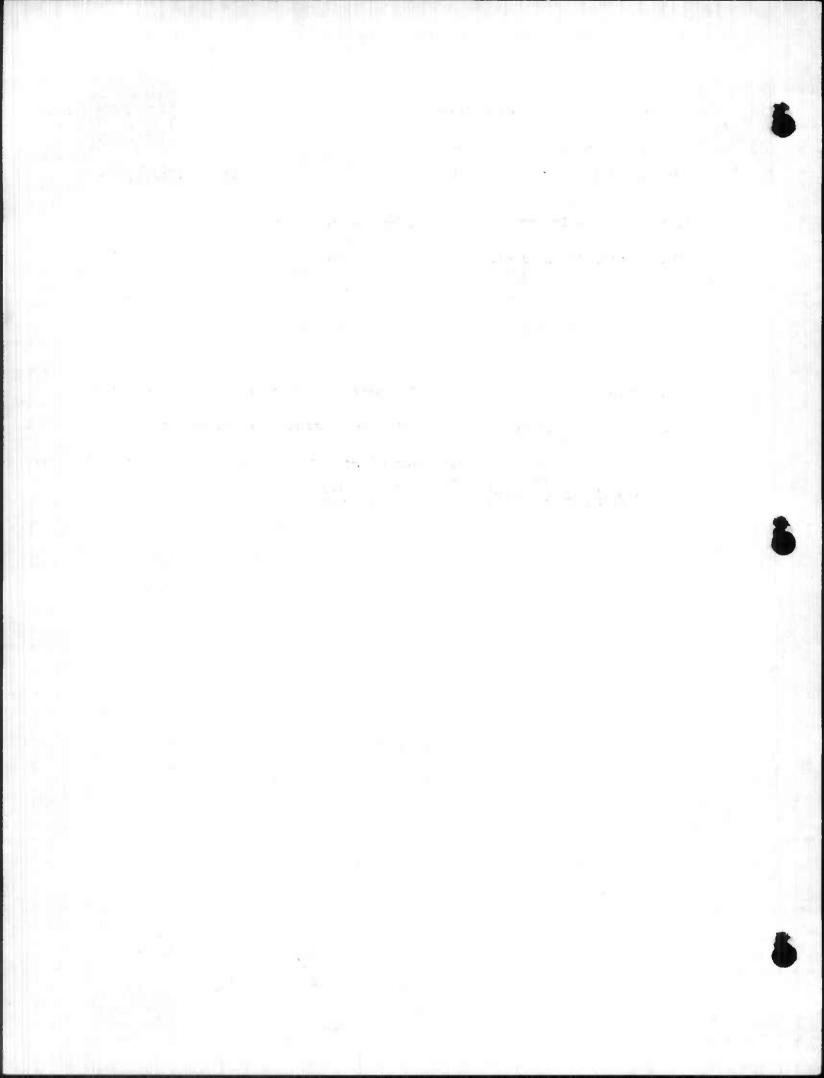
Daiy 64

29d. Date signed (Month, Day, Year)

DHMH 16 Ray 6/95

(Check only one)

29b. Signeture and title of cartifler

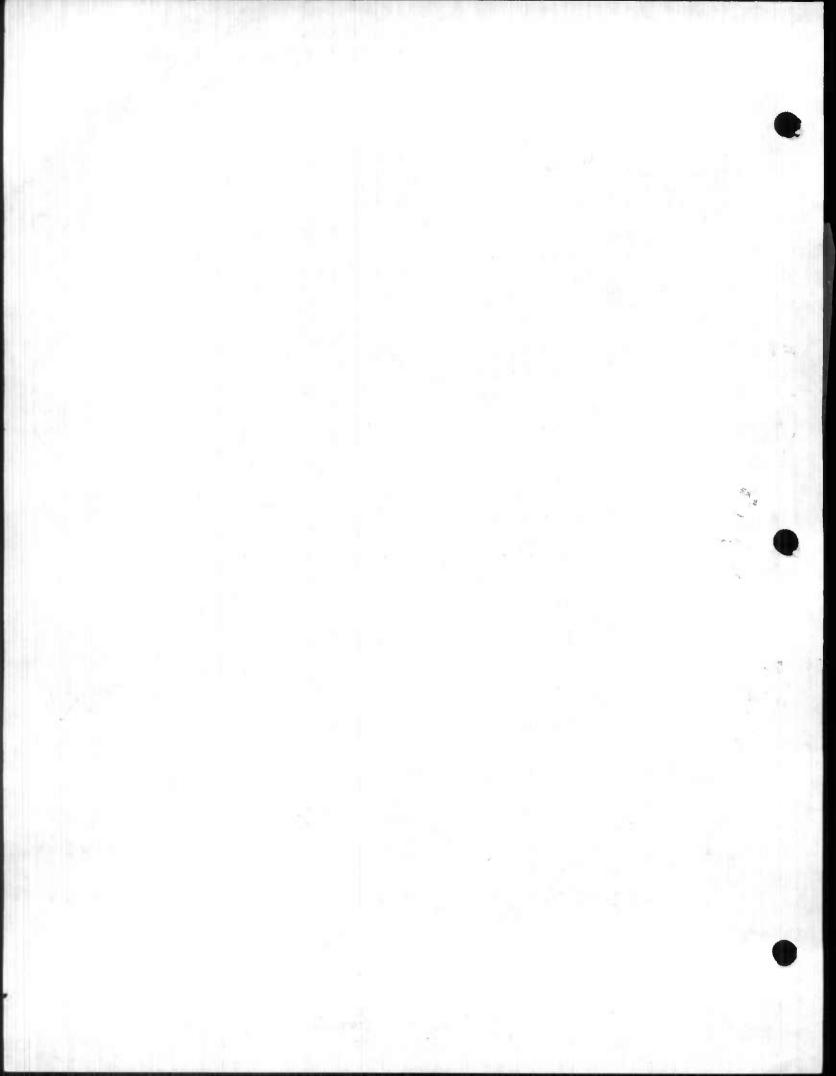


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

1. Decedent's Name (First, Middle, La	e cf)		Certifica	ate of	Death	2. Date of D	Heg. No.	J ()	0 3 2
MILES H. DAVIS						Month	Day	Yaar	730
MILES H. DAVIS 4a Facility Name (If not institution, given		r)			4b. City, Town, o	or Location of Dea		DOO ty of Death) (AM
RAVENWOOD NURS	SING HOM	E			BALTIM	ORE		NI	9
	Sex 7. A	Age (In yrs. last	Yrs. If Uni	der 1 Yaar Is Days	If Undar 24 H Hours M		rth ay, Year) 7-63	9. Birth	place (State or I
Usual Residence of Decedent		1.0 07 7				101-21		-	10.1 1 00
10a. Sfata 10b. County			own or Location						10d. Inside City
MD N/A		BALTI	MORE	Zip Code			10g. Citizen of	What Co.	
	INE AVEN	hus.	101.	210	12			USA	21 th y t
11. Marital Status	12. Was Deceden	nt Ever in U,S.	13. Was De	cedent of H	lispenic Origin?	(Specify Yes or Nerto Rican, etc.)		ca - Amer	ican Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas 1 Yas 2 If Yes, Give Year or Dates	No			Specify:	eno Hican, etc.)	Speci	ack, White	ACK
15. Decedent's E	ducation	1	6a. Decedent's U	sual Occup	eation during most of v	und ina	16b. Kind of I	Business/I	ndustry
(Specify only highest grant Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. DO NO	use retire	d)	VOIKHIY	Denta		
12 TH GRADE	1 YR		Coo	DK _	10 14-1-1	lama (Eirot Adida)	RESTA	-	O1
17. Father's Name (First, Middle, Last	r)					lama (First, Middle	ь, меюеп Sume	ii19 <i>)</i>	
HERBERT DAVIS 19a. Informant's Name/Relationship	(Type Print)		19h Mailina Add-	ace /Stract	1LONA	MISE Rurel Route Num	her City or Tour	State 7	in Code)
1	MOTHER		3132 RHE			ALTO. MI			0000)
20a. Method of Disposition		20b. Plac	e of Disposition (I			Data	20c. Location		Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ea	MEMORI	_		1-15-2006	RANDA	11917	WN , M
21. Signature of Funeral Service Lice		retract	22 Name	and Addre	es of Facility				1
121 0	> H_		VAUGH	NC.	GREEN NATL' P	E FUNE	RAL SEA	SVICE	21229
23a. Part1. Enfar the disease, or comshock, or heart failure. List only	nplications that caus	ed tha daath.						. 2	Approximate Interval Between
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events	D	-2.00000000000	a consequence	MUI					
resulting in death) Last	d	Due to (or as	a consequence of	4.					
	anatulbusina ta dansh	hut not socialis	a in the conduct de		Thirty and			omtelbuto.	to the gauge of
Ung II Other algorithment conditions	Contributing to death	OUL HOLFBSUIGE	IN ALL THE RUDGERAIN	u cause dr		22h Di	I tobacco uses a	WHITE THE PARTY OF	to the canas of
Part II. Other algnificant conditions of					ven in Part I.		tobacco use o Yea 2□ No	3□Pr	obebty
Part II. Other eignificant conditions					ven in Part I.	1 [24a. We		24b. V	Wara autopsy fin available prior to completion of ca
Part II. Other eignificant conditions					ven in Part I.	1 [24a. We	Yea 2□ No s an autopsy formed?	24b. V	Wara autopsy fir available prior to completion of capf death?
						24a. We per	yea 2□ No s an autopsy formed? Yes 20 No	24b. V	Wara autopsy fin available prior to completion of ca
25. Was casa rafarred to medical axaminar?	Hospital: 1 □ Inpa	tient 2∏F¤		Ott	26. Placa of I	24a. We per	yea 2□ No s an autopsy formed? Yes 20 (No ona)	24b. V	Wara autopsy fiir invaliable prior to completion of capf death?
25. Was casa rafarred to medical axaminar?	28a. Date of In (Month, D			DOA Ott	26. Place of I	24a. We per 1 Check only g Home 5 Res	yea 2□ No s an autopsy formed? Yes 20 (No ona)	24b. V	Wara autopsy fiir invaliable prior to completion of ce of death?
25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, Don be 28e. Placa of I	ojury 28 Day Year)	VOutpatient 3D	DOA Ott	26. Placa of I	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location	yea 2 No s an autopsy formed? Yes 2 No ona) sidenca 6 00	24b. V	Wara autopsy fin available prior to completion of ce of death?
25. Was cass referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation of the could not be determined. 3 Suicide 6 Could not be determined. 29a. Certifier Check only Medical Exercises	28a. Date of In (Month, L) 28e. Placa of I building, (Month) 28e. Placa of I building, (Month)	injury - Af home etc. (Specify)	VOutpatient 3D Bb. Time of Injury M a, farm, streaf, fac	DOA Ott	26. Placa of I	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location City or Trace, and due to the	yes 2 No s an autopsy formed? Yes 2 No ona) sidenca 6 0 s how injury occi (Street and Num own, State)	24b. Value of their (Specured onber or Rumannar as	Wara autopsy fir available prior to completion of ca of death? I Yes 2 N cify)
25. Was casa rafarred to medical axaminar? 1	28a. Date of In (Month, Don be do	injury - Af home etc. (Specify)	I/Outpatient 3D bb. Time of Injury M e, farm, streaf, faced or stream of the stream	DOA Ott	26. Placa of Iner: 4 Nursin ry at rk? Yes 2 □ No	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location City or Trace, and due to the	yes 2 No s an autopsy formed? Yes 2 No ona) sidenca 6 0 s how injury occi (Street and Num own, State)	24b. Van Control of the Control of t	Wara autopsy fin ivaliable prior to completion of ca of death? I Yes 2 N City) Interest Route Numb Stated. It to the cause(s)
25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be datermined datermined. 29a. Certifier (Check only one) 1 Certifying Pt Medical Exam	28a. Date of In (Month, L) 28e. Placa of I building, (Month) 28e. Placa of I building, (Month)	injury - Af home etc. (Specify)	I/Outpatient 3D bb. Time of Injury M e, farm, streaf, faced or stream of the stream	DOA Ottl 28c. Inju Wo 1 □ lory, offica	26. Placa of Iner: 4 Nursin ry at rk? Yes 2 □ No	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location City or Trace, and due to the	yes 20 No s an autopsy formed? Yes 20 No ona) sidenca 6 00 how injury occit (Street and Numbern, Stata) a causa(s) and right, date and place	24b, visit of their (Special Internal I	Wars autopsy fire variable prior to completion of ca of death? I Yes 2 I
25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation of the properties of the propertie	28a. Date of In (Month, Don be don building, thysician: To the basis and manner:	injury - At home etc. (Specify) st ot my knowle of examination statad.	VOutpatient 3 Db. Time of Injury Me, farm, streaf, facedga, daath occurr a and/or invastigat	DOA Ottl 28c. Inju Wo 1 □ lory, offica	26. Placa of Iner: 4 Nursin ry at rk? Yes 2 □ No	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location City or Trace, and due to the	yes 20 No s an autopsy formed? Yes 20 No ona) sidenca 6 00 how injury occit (Street and Numbern, Stata) a causa(s) and right, date and place	24b. Van Control of the Control of t	Wars autopsy fin available prior to completion of ce of death? I Yes 2 I
25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation of the properties of the propertie	28a. Date of In (Month, Don be don building, thysician: To the basis and manner:	injury - At home etc. (Specify) st ot my knowle of examination statad.	I/Outpatient 3D bb. Time of Injury M e, farm, streaf, faced or stream of the stream	DOA Ottl 28c. Inju Wo 1 □ lory, offica	26. Placa of Iner: 4 Nursin ry at rk? Yes 2 □ No	24a. We per 1 Death (Check only g Home 5 Re: 28d. Dascribe 28f. Location City or Trace, and due to the	yes 20 No s an autopsy formed? Yes 20 No ona) sidenca 6 00 how injury occit (Street and Numbern, Stata) a causa(s) and right, date and place	24b, visit of their (Special Internal I	Wara autopsy fili valiable prior to completion of ce of death? I Yes 2 1 city) stated. to the cause(s)

DHMH 16 Ray 6/95

C C



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	#26 PER MD 1. Decedent's Nam						·············	of Dea		2. Date of D				3. Time of Death
cian dical	Diann				Done	glas		Dor	rtch	O1	17	200	ear OO	10:13am
	4a Facility Neme ((If not instituti	ion, give	street end nu		9240				Location of Dea	ath 4c.	County of E	Death	
	92 Ken	an St	reet	t				O Date of	Caney			Carr	coll	L Co.
1	5. Social Security I		6. Ser	к]м 2 [X F	7. Age (In yr. 48	s. lest birthdey, Yrs.	Months I	Year If Un Days Hou	nder 24 Hrs urs Min.	(Month, L	Day, Year)	9.	Birthpl	ace (Stete or Foreigny)
	212-58- Usuel Residence of				40	113.				04	10 5	51	S	С.
H	10e. State	10b. Count	.,			City, Town or L		-					10	d. Inside City Limit
	MD	Carr	oll	Co.		Taney	Town							1 ☐ Yes ŽŒN
	10e. Street and Nu 92 Ken		ree	t			10f. Zip C	787				U.S.A		ry?
	11. Marital Status 1 Never Men 3 Widowed		arried	12. Was Deci Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 🔯 No ve	U,S. 13.	Wes Deceder If Yes, specifi			pecify Yes or No Rican, etc.)		14. Reca - A Black, V Specify:		tc.
	40	15. Decede				16a. Dece	edent's Usual	Occupation		tion	16b. KI	Ind of Busine		
	Elementery/Sec	cify only high ondery (0-12)		College (1-4or 5+)	life.	e kind of work DO NOT use	aone auring ratired)	most or wo	rking				D = m la
	12th			lyrs		Cı	ustome					Nat	. Т	Bank
	17. Father's Neme			. ,						me (First, Midd				
-	Haskel					10h Mall	ina Address (ine Li			ata Zin	Code
	19a. Informant's N				sband					ral Route Num				21787
F	20a. Method of Dis		701. 0	011 110		. Placa of Disp	osition (Neme	of		Date	-	ocation - City		vn, Stete
4	1 Burlal 2			temovel from	State	camerery, cre	emetory or oth	orplece)	Par	1/21	/200	O Arl	but	us, Md
ı			(Spacify)					74 101		/				
	4 ☐ Donation 21. Signature of F			88			2. Name and	Address of F	acility				-, -	
	4 Donation			00 L.	Que A	2 M	2. Name and	W H/S	est	Balt	imor	ьм а		
1	4 □ Donation 21. Signature of F	met	te License	K	In	es 4	arch 300 Wa	H Wabash	est Ave	, Balt		e Md		1215
1	4 Donation	met	te License	K	In	es 4	arch 300 Wa	H Wabash	est Ave			e Md		1215
1	4 Donation 21. Signature of F 23. Part 1. Enter- shock, or her Immediate Cause disease or condition	the disease, art failure. Li	te License	ications that one cause on g	osed the de	eth. Do not er	22. Name and arch 1 300 Wanter the mode	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Md		1215 Approximate Intervel Between
7	4 Donation 21. Signature of F 233 Fart1. Enter shock, or free	the disease, art failure. Li	te License	ications that one cause on g	of ed the de	es 4	22. Name and arch 1300 Wanter the mode	P/H Wabash abash of dying, suc	Ave has cardie		arrest,	e Md		1215 Approximate Intervel Between
X	4 Donation 21. Signature of F 23. Part 1. Enter- shock, or her Immediate Cause disease or condition	the disease, art failure. Li	te License	ications that one cause on g	of ed the de	M. 4	22. Name and arch 1300 Wanter the mode	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Mđ		1215 Approximate Intervel Between
	4 Donation 21. Separative of F 23. Fant. Enter shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it	the disease, and failure. Li (Final on	te License	ications that one cause on g	bed the de	M. 4	22. Name and arch 300 Wanter the mode	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Md		1215 Approximate Intervel Between
	4 Donation 21. Senature of F 23. Fart1. Entery shock, or the conditions of the condi	the disease, art failure. Li (Final on anditions, mmediate enlying r thiury	te License	ications that one cause on g	Due to	deth. Do not er (or as a consector of conse	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Md		1215 Approximate Intervel Between
	4 Donation 21. Separative of F 23. Fant. Enter shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it	the disease, art failure. LI (Final on anditions, mendiate eriying r Injury is	te License	ications that one cause on g	Due to	eth. Do not er	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Md		1215 Approximate Intervel Between
	4 Donation 21. Separate of F 23. Part1. Enter shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or hat initiated event	the disease, art failure. LI (Final on anditions, mendiate eriying r Injury is	te License	ications that one cause on g	Due to	deth. Do not er (or as a consector of conse	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash abash of dying, suc	Ave has cardie	c or respiratory	arrest,	e Md		1215 Approximate Intervel Between
	4 Donation 21. Separate of F 23. Part1. Enter shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or hat initiated event	the disease, art failure. Li (Final onditions, mmediate enlying r Injury is Last	or compliant only or	ications that cause on g	Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash of dying, suc	est Ave th as cardie	c or respiratory	arrest,		2	1215 Approximate Intervel Between
	4 □ Donation 21. Senature of F 23. Fart1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und cause (Disease or that initiated event resulting in deeth)	the disease, art failure. Li (Final onditions, mmediate enlying r Injury is Last	or compliant only or	ications that cause on g	Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash of dying, suc	est Ave th as cardie	c or respiratory	arrest,	use contri	2	1215 Approximate Intervel Between Onset and Death Year the cause of death
	4 □ Donation 21. Senature of F 23. Fart1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und cause (Disease or that initiated event resulting in deeth)	the disease, art failure. Li (Final onditions, mmediate enlying r Injury is Last	or compliant only or	ications that cause on g	Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash of dying, suc	est Ave th as cardie	23b. DI	arrest,	use contril	2 ibute to Prob	1215 Approximate Intervel Between Onset and Death Year the cause of death
	4 □ Donation 21. Senature of F 23. Fart1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und cause (Disease or that initiated event resulting in deeth)	the disease, art failure. Li (Final onditions, mmediate enlying r Injury is Last	or compliant only or	ications that cause on g	Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode equence of):	P/H Wabash of dying, suc	est Ave th as cardie	23b. Di 10	arrest, id tobacco Vee 2	use contril	2 libute to Prob	1215 Approximate Intervel Between Onset and Death Lycus the cause of death ebly 4 Unkno
	4 Donation 21. Senature of F 23. Fart1. Entery shock, or her shock, or her disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in deeth) Part II. Other eigni	the disease, art failure. Li (Final on anditions, mmediate entying r Injury s Last	or complist only of	ications that cause on g	Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode equence of):	e H Wabash of dying, such	est Ave. Ave.	23b. Di 10	d tobacco Yee 3 as an autor rformed?	use contril	2 libute to Prob	Approximate Intervel Between Onset and Death Personal Per
	4 Donation 21. Senature of F 23. Fart1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in deeth) Part II. Other eignt	the disease, art failure. Li (Final on ditions, mmediate entying thirty is Last	or complist only or	ications that cause on g	Due to Due to	deth. Do not er (or as a consector (or a) (o	22. Name and a rch 300 Wanter the mode arch 1300 was equence of): equence of): equence of): equence of): equence of): equence of):	se given in I	est Ave. Ave.	23b. Di 1(24a. Wy pe	d tobacco Yee 2 as an autor formed? Yes 2 y one)	use contril	2 Prob	Approximate Intervel Between Onset and Death Lycys the cause of death ably 4 Unkno ore autopsy findings illable prior to nopletion of cause deeth? I yes 2 No
	4 Donation 21. Senature of F 23. Part 1. Entery shock, or the shock, o	the disease, art failure. Li (Final on ditions, mmediele enlying r Injury) s. Last	or complisit only or	dospitei: 1 □ 28a. Date	Due to Due to Due to	(or as a consector as	22. Name and a rch 300 Wanter the mode of	se given in I	est Ave has cardie	23b. Di 1(24a. Wy pe	d tobacco Yee 2 as an autor formed? Yes 2 y one)	psy 2	2 24b. We ave cor of a control of the control of th	Approximate Intervel Between Onset and Death Lycys the cause of death ably 4 Unkno ore autopsy findings illable prior to nopletion of cause deeth? I yes 2 No
	4 □ Donation 21. Senature of Figure 1. Enterphock, or her disease or conditive resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in deeth) Part II. Other eigni	the disease, art failure. Li (Final on ditions, mmediate enlying r Injury is Last	or complisit only or	dospitel: 1 28a. Date (Mon	Due to Due to Due to Due to Due to Inpatient 2 of Injury (th, Dey Year)	deth. Do not er (or as a consection of the cons	22. Name and a rch 300 Wanter the mode of squence of): equence of): equence of): underlying cau ont 3 DOA of 286 M	Se given in I	est Ave has cardie	23b. Di 10 24a. Wipe ath (Check on) 10 28d. Describ	d tobacco Yee 3 as an autor formed? Yes 2 y one) sidence he how injury	psy 2	224b. We aver cold (Specify)	1215 Approximate Intervel Between Onset and Death Yess the cause of death abby 4 Unknown autopsy findings (liable prior to impletion of cause leeth? Yes 2 No
	4 □ Donation 21. Senature of F 23. Fart1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in deeth) Part II. Other eigniting in deeth) 25. Was case referenced and in the cause (Disease or that initiated event resulting in deeth) 25. Was case referenced in the cause (Disease or that initiated event resulting in deeth)	the disease, art failure. Li (Final on ditions, mmediate entying r Injury s Last Ifficant conditions to mediate entying r Injury s Last	or complisit only or	dospitei: 1 28a. Date (Mon	Due to Due to Due to Due to Due to Inpatient 2 of Injury (th, Dey Year)	(or as a consection of the following in	22. Name and a rch 300 Wanter the mode of squence of): equence of): equence of): underlying cau ont 3 DOA of 286 M	Se given in I	est Ave has cardie	23b. Di 1(24a. Wingstein St. Check on) 1-lome St. Re 28d. Describ 28f. Location	d tobacco Yee 3 as an autor formed? Yes 2 y one) sidence he how injury	psy 2 Other (ry occurred	224b. We aver cold (Specify)	Approximate Intervel Between Onset and Death Lycys the cause of death ably 4 Unkno ore autopsy findings illable prior to nopletion of cause deeth? I yes 2 No
	4 Donation 21. Senature of Fart 1. Entry shock, or her disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und cause (Disease or that initiated event resulting In deeth) Part II. Other eigning the examiner? 1 Yes 2 27. Manner of Dea 1 Yes 2 28. Certifier (Check only)	the disease, art failure. Li (Final on ditions, mmediate entying I Injury s Last Ifficant conditions to mediate entying I injury s Last	or complist only of	dospitei: 1 28a. Date (Mon 28a. Place buildi	Due to	deth. Do not er (or as a consection of the cons	22. Name and a rch 300 Water the mode arch 1300 Water the mode arched ar	Se given in I	est Ave. Ave. has cardie Part I. Place of De Nursing I 2 \(\) No	23b. Di 1(24a. Wingstein St. Check on) 1-lome St. Re 28d. Describ 28f. Location	d tobacco Yee as an autor rformed? Yes yone) esidence he how injur (Street err own, Stele	psy 2 6 Other (ry occurred	bute to Prob Security (Specify) or Rura	Approximate Intervel Between Onset and Death Onset and Death I years the cause of death webly 4 Unknown or autopsy findings illable prior to impletion of cause deeth? I yes 2 No
	4 □ Donation 21. Senature of F 23. Fant1. Entery shock, or her Immediate Cause disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in deeth) Part II. Other eignification of the cause (Disease or that initiated event resulting in deeth) Part III. Other eignification of the cause (Disease or that initiated event resulting in deeth) 25. Was case reference or campaigness of the cause of the cau	the disease, art failure. Li (Final on ditions, mmediale entying r Injury is Last To Could determine the Could determine the medicular conditions and the could determine the could dete	or complist only or tions con	dospitei: 1 28a. Date (Mon 28a. Place buildi	Due to Due to	deth. Do not er (or as a consection of the cons	22. Name and a rch 300 Wanter the mode of	Se given in I	Part I. Place of De Nursing I 2 No	23b. Di 10 24a. Winger 11 ath (Check on) 128d. Describ 28d. Describ 28d. Describ	d tobacco Yee 2 as an autor formed? Yes 2 yone) sidence he how injure in (Street errown, Stefe in e cause(s), e, date end	psy 2 6 Other (ry occurred) and manned place, and	224b. We aver cord of a fural for Rura	1215 Approximate Intervel Between Onset and Death The cause of death the cause of death about 4 Unknown or autopsy findings (liable prior to impletion of cause leeth? The cause of death Approximate intervel Between Onset autopsy findings (liable prior to implet on of cause leeth? The cause of death at the cause of death the cause of death at the cause of death the cause of death
	4 Donation 21. Senature of Fart 1. Entry shock, or her disease or condition resulting in death) Sequentially list or it any, leading to it cause. Enter Und cause (Disease or that initiated event resulting In deeth) Part II. Other eigning the examiner? 1 Yes 2 27. Manner of Dea 1 Yes 2 28. Certifier (Check only)	the disease, art failure. Li (Final on ditions, mmediale entying r Injury is Last To Could determine the Could determine the medicular conditions and the could determine the could dete	or complist only or tions con	dospitei: 1 28a. Date (Mon 28a. Place buildi	Due to	deth. Do not er (or as a consection of the cons	22. Name and a rch 300 Wanter the mode of	Se given in I	Part I. Place of De Nursing I 2 No	23b. Di 10 24a. Wipe 11 24b. Describ 28d. Describ 28d. Location City or 1	arrest, d tobacco Yee 2 as an autor formed? Yes 2 y one) sidence he how injure (Street errown, Stete the cause(s) e, date end 29d. Da	psy 2 Other (ry occurred) and manned place, and	24b. We aver cord (Specify) (Specify) or Rura	1215 Approximate Intervel Between Onset and Death The cause of death the cause of death about 4 Unknown or autopsy findings (liable prior to impletion of cause leeth? The cause of death Approximate intervel Between Onset autopsy findings (liable prior to implet on of cause leeth? The cause of death at the cause of death the cause of death at the cause of death the cause of death

DHMH 16 Rev 6/95

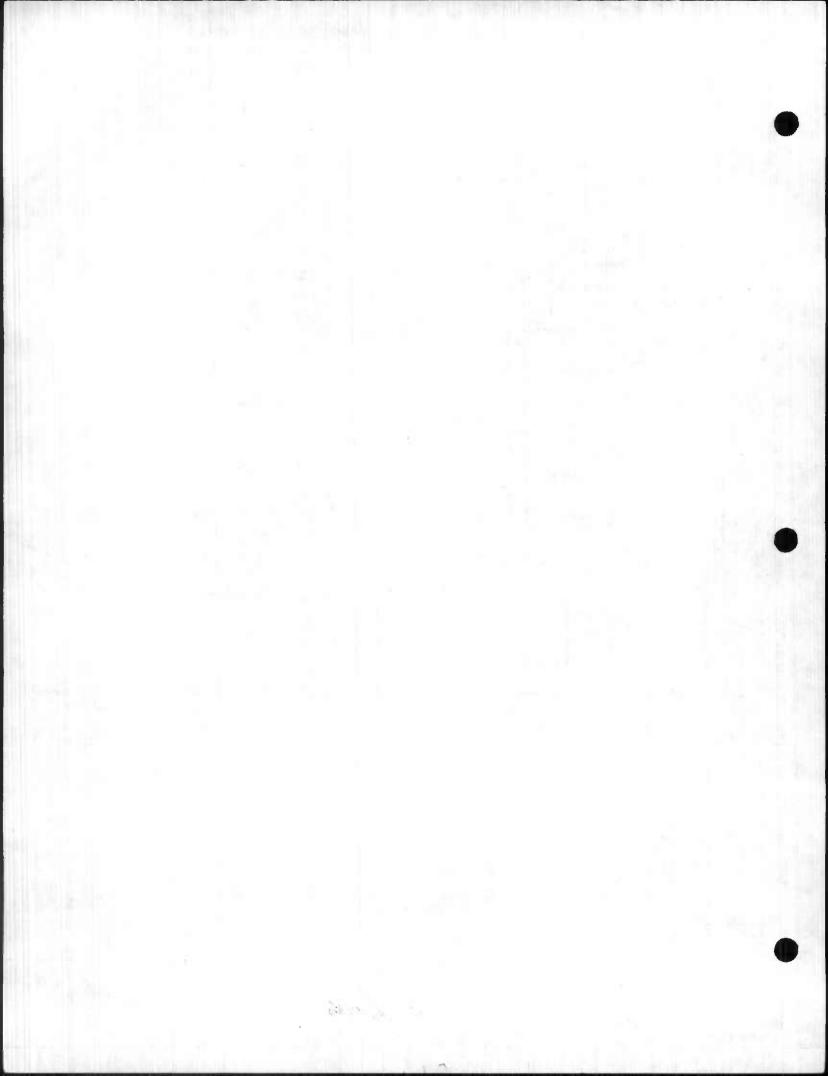
more houself literation

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

					Certificate of D	eath		Reg. No.	0 ()1325
	Ob		1. Decedent's Name (First, Middle, L	ast)			2. Date of De		Year	3. Tima of Death
	Physici /Medic		trances	Dublin			UAN		000	12:30AM
	Examir		4a Facility Neme (If not Institution, go	ve street and number)	. 1 1 46.	City, Town, or Loc	ation of Death	4c. County	of Death	1
			Greenspring Ke	nab, and Nur	sing Center :	Balti	more		VI	
Н	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. II		If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da	h y, Ypan 17	9. Birtho	lace (State or Foreign
	Director		Usual Residence of Decedent	1 800	110.	4	June	111/	1119	rylana
	yland m		10a. Steta 10b. County	10c. City				1	0d. Inside City Limits	
	hours after death with the Maryland ural; or items 23s or 28s-f show Illeaning must be notified at	tor	Maryland N/	4 F	Paltimore					1 No
		Director	10e. Street and Number		101. Zip Code	4.0		10g. Citizen of V	What Coun	try?
			3702 Gelst	on Drive	2/20	29		4	SA	
	Herra Herra Free m	Funeral	11. Meritel Stetus	12. Wes Decedent Ever in U,S Armed Forces?	S. 13. Wes Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	cify Yes or No-	14. Rec	e - Americ	
50	or the		1 ☐ Never Merried 2 ☐ Merried	1 ☐ Yes 2 ☒ No If Yes, Give		Specify:		Boscit	r^	1.
5-0020	ural.	d by	3 Widowed 4 □ Divorced	Year or Dates:				VHT	ican	Hmerican
15	72	lete	15. Decedent's E (Specify only highest g		16a. Decedent's Usuat Occupation (Give kind of work done dur Jife, DO NOT use retired)	on ring most of workin	g	16b. Kind of Bu	usiness/Inc	lustry
2121	within than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Machinis	+		MARI:	nd 7	- ndustries
	Hyg office one,	Be C	17. Father's Neme (First, Middle, Las	0	11	8. Mother's Name	(First, Middle,	Maiden Sumen	10)	71903 11163
lar	tente Aced Aced	To B	Edward A	1. Gray		Borth	a P	Bosti	CK	
aryland	ahou Mund N		19a. Informent's Neme/Reletionship	(Type, Print) Sister)	19b. Meiling Address (Street and	d Number or Rural	Route Number	er, City or Town,	Stete, Zip	Code)
Z	and 2 seith 1 or tre		Mrs. Beulah	Hamiel	3702 Gelst	on Dr	ive '	Balto	. M.	1.21224
ore	of Heel		20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremetion 3 I	00	ace of Disposition (Neme of ametery, cremetory or other place)	1/	Dete	20c. Location -	City or To	wn, State
aitimore	nit. Pages artment of ortant: if its injury or o		4 Donation 5 Other (Spec		It. Auburn	1/0	25/2000	Balt	0. 1	VId.
ait	pour pour pour pour pour pour pour pour		21. Signalure of Funerel Service Lice	insee (), ()	22. Name and Address	of Facility	7	1 /	/	
0	20779		salehh)	L. Kuss	Joseph L	JOY 455	troun	Brail t	Right	21216
			23a. Part . Enter the disease, or cor shock, or heart failure. List only	iplications that caused the death	. Do not enter the mode of dying,	such as cardiac or	respiretory er	rest,		Approximete Interval Between
	Physician		U .						6	Onset and Deeth
1	/Medical Examiner		tmmediete Cause (Final disease or condition resulting in death)	a. ACU	DRY FI	FAILURE			DAYS	
		1	rooming ar coatry		as a consequence of):					
	per lise	nln			105CLEROTIC	HEART	DISE	FASE		YEARS
	be executed sician and burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or						
68760,	sician e burlai	edical	that initieted events	C. Duo to for						
.89	g physics the the		resulting in death) Last	Due 10 (01	es a consequence of):					
Вох	andin use	2		d					i	
	sicien: The law requires that the death cert cartificate hes been signed by the extendin irector, page 2 should be deteched for use	Physician/N	Pert It. Other significant conditions	in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
P.0.	by the	Phy	HY							
s,	es the	þ		PERTENSIO					T	
ord	aduir s den s	ted	PA	RKINSONS DIJEASE			24e. Wes an autopsy performed?		24b. Were autopsy findings available prior to	
90	es b	g.							of	mpletion of cause deeth?
=	off tate	Completed					101	res 2 No	t E	Yes 2□ No
/Ita	Physician: rthis cardific real director,	8	25. Wes case referred to medicat axaminer?			26. Place of Deeth				
of	this c	2	1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2 E	ER/Outpatient 3 DOA Other: 28b. Time of Injury a Work?	412 Nursing Horr				1)
Division of Vital Records,	Ather Uner	lon:	27. Manner of Death 1 Meturel 5 ☐ Pending		8d. Describe f	now injury occur	red			
S	death death tor:	cat	2 Accident investigation 3 Suicide 6 Could not l	De Dies of leive, 44 hou	s 2 No	9f Location /	Straat and Numb	or or Run	I Route Number,	
2	Or A Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify,	me, farm, street, fectory, office		City or Tov		rer or nura	Thouse Number,
	ours filled		29e. Certifier 1P Certifying P	hysician: To the best of my know	viedge, death occurred at the time,	date and place, as	nd due to the	cause(s) and me	nner as si	lated
	To the Mospital or Attending Physicien: The is within 24 burns effect death. To the Funeral Director: After this cardificate he temperately filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis of examinati and manner steted.	ion and/or investigation, in my opin	ion, deeth occurre	d at the time,	date and place,	and due to	the cause(s)
	To the Within	Me	29b. Signeture and title of certifier	^	29c. License n	number		29d. Date signe	d (Month,	Day, Year)
	1/		1 B. C. U	nera conte	400A D	1366	64 Jan 17, 2000			
	11/2	1	30. Nama end eddress of person who	completed cause of death (ttem	23a) (Type, Print)					
	100	1	B.C. VENERA	CION JR MD PA	1574 MERRIT	T BLVD	, BA	LTO,	MD	. 2/222
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signate	ure & Sporks		-			
	Registra	ar	JAN 2 1 200	10 A reco	10 popular	7				

DHMH 16 Rev 6/95

--- 0 a 2004



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent'a Name (First, Middla, Last) Day Month Year **Physician** THOMAS DOBBS T, SR. January 18 2008 2000 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston General Hospital Fallston Harford If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F 215-03-6480 Director Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore 1 Yas 3 No Director Baltimore 288-7 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 8034 Lansdale Road 21224 Items 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, apecify Cuban, Maxican, Puerto Rican, atc.) 12. Was Dacedent Evar in U.S. 14. Race - Amarican Indian, 11 Marital Status Armed Forcas?

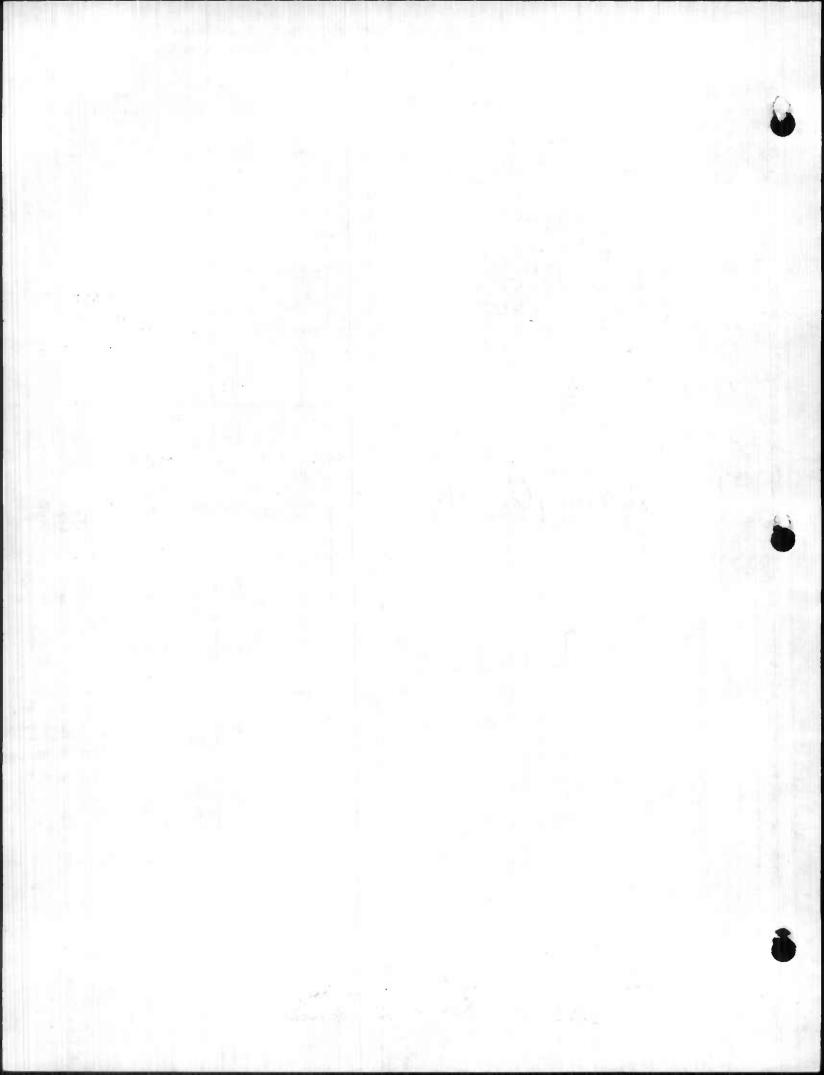
1. Yas 2 □ No if Yas, Giva Black, White, etc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yas 21 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: Completed t5. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Bugle Linen & Supply Salesman 9th 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) 86 Pages 1 and 2 should be nent of Health and Mental William W. Dobbs Sadie E. Merriken 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health as Important if them 27 is any injury or other trau Thomas L. Dobbs Jr. /son 5819 Gambri Road White MArsh Md. 21162 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, cremetory or other place) Data 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Ramoval from State Oak Lawn Cemetery 4 □ Donation 5 □ Othar (Specify) 1/21/2000 Baltimore Md. 21. Signatura of Funaral Sarvice Licenses 22. Nama and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disaasa, or complications that caused tha death De not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only of a cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner physician and the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Causa (Diseasa or Injury Dua to (or as a consequence of): Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of): 980 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Momas ρ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed deligolistio 1 Yes 25 No 1 Yes 2 No or Attanding Physician: Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Nopatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding n 24 hours after death.

Ne Funeral Diractor: After the full of th 1 Yas 2 No invastigation 2 Accidant 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcide 4 Homlcida Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) To the P within 2 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D32295 19,2000 30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print) 45 2. 31. Data filed (Month, Day, Year) 32. Registrario Signatura 1 20 nn Denews. JAN 2 Registrar

ORIGINAL

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day Bowler Delanev Henry 20, 2000 8:30 AM January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 112 Glen Argyle Road Baltimore Towson 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth Month Day, Year) May 27, 1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 10XM 20 F 231-58-3444 53 Yrs. Oregon Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d, Inside City Limits Baltimore Maryland Towson 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21212 112 Glen Argyle Road United States 14. Rece - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U.S. Armed Forcas? Wes Dacedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Status 198Yes 2□No If Yes, Give Year or Dates: Vietnam War 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) US Government Congressional Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Bowler Delaney Ruth Shecherd 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Carl Skoggard/ Friend 28 E. 73rd Street New York, NY 10021 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20c. Location - City or Town, Stata 20a. Method of Disposition Dete 1 ☐ Buriel 2XXCremetion 3 ☐ Removel from State Chesapeake Crematory, Inc. 1-14-00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility CAFA Stephen D. Lohmann P.A. 21. Signature of Funaral Sarvice Licenses Laura Nandeste 8717 Green Pastures Drive Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Buoutl Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 1 Yes 2 NO 1 ☐ Yes 2 No 25. Was case referred to medicel examiner? 26. Plece of Death (Check only one)

The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, signed by i has certificate or Attanding Physician: After this s after deau...al Director: Afte

Physician/Medical Examiner by Completed Be 10 Certification:

Physician

/Medical

Directo

Funeral

à

Completed

Be

Examiner

Funeral

Director

"nature", or items 23a or 28a-f show

than

Hygiene.

is marked of

important: if them 27 is in any injury or other 27 is in 2008.

Physician

/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0020

the Medical Examiner must be notifie

1 Yes 2 No 27. Menner of Deeth

1 Neturel 2 Accident 3 Suicida 4 Homicide

29a. Certifier

31. Date filed (Month, Day, Year)

JAN 2 1

**Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signiture and 906 of centiful

Hospital: 1 ☐ Inpatient

28e. Date of Injury (Month, Day Year)

DIRECTOR, MEDICAL OUCDLOBY

Jener

29c. Licanse number 1023675

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year) January 20, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Mullom 30. Nama and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ROSS C. CONCHOUGE, WID

2000

John & Hopkins 32. Registrar's Signeture

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Be House, UND

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

State Registrar

DHMH 16 Rev 6/95

illed in by

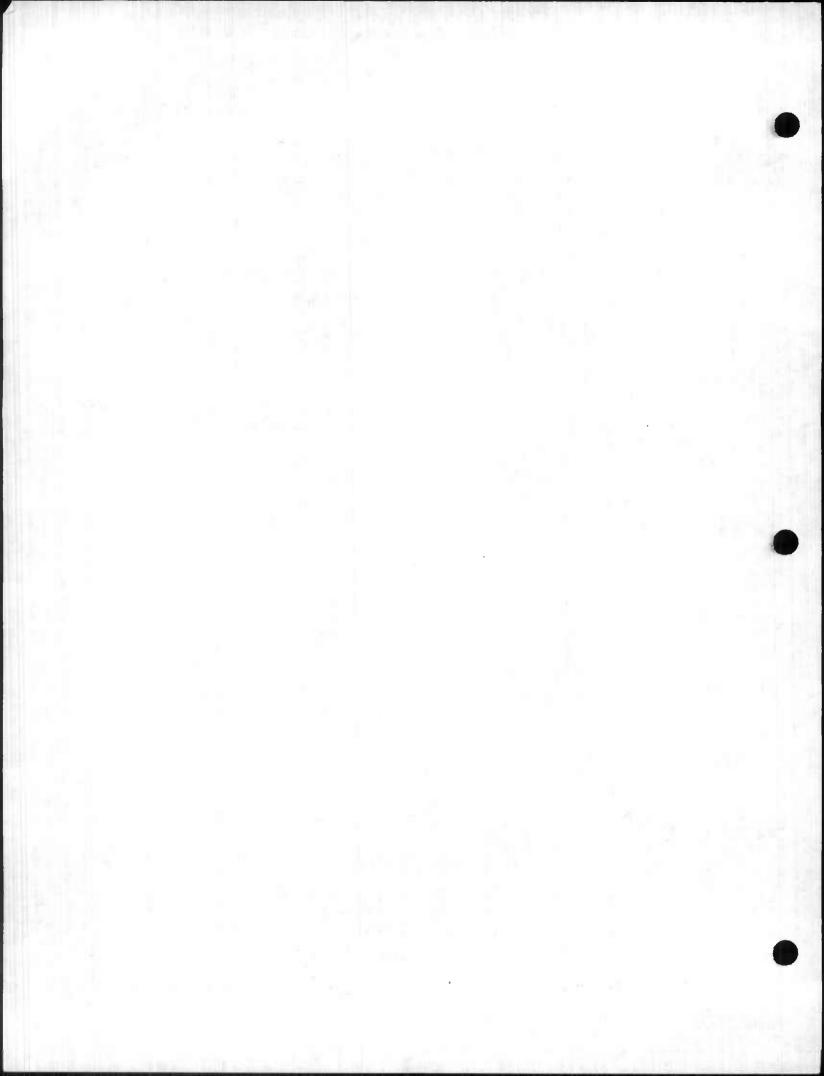
edical

within 24 hours a To the Funeral C completely filled To the Hospital

> === 0 2001

5 Pending investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS #2, #7 PER MD & FH G779 1/21/2000 AH 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 1/4/2000 **Physician** Month 12:30 A Maru auis /Medical SUGE Acpps 4b. City, Town, or Location of Death 4e. Fecility Nama (If not institution give street and number) Funder 24 Hrs. 8. Date of Birth (Month, Day) 4c. County of Deeth Examiner manor Undar 1 Yaar Deys 7. Aga (In yrs. last birthday) MD Kaltimore 5. Sociel Security Number Birthpleca (State or Foreign Country) **Funeral** 1 M 2 F Deys 812-09 Usuel Residence of D Director Baltimore City, Md. Decedent with the Maryland 10e Stete 10b. County Show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Nems 23a or 28a-f si the Medical Examiner must be notified 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 12. Wes Decedant Ever in U,S.
Armed Forcas?
1 Yes, 2 M No
If Yes, Give
Yaar or Dates: Funerai Saltmor death Wes Dacedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 11. Maritai Status filed within 72 hours after 1 Naver Married 2 Married 21215-0020 1□ Yes 250No Specify: by Specify: 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) Housewife Housekeeping-Own Home other 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any Injury or other traumetic event once. 18. Mother's Neme (First, Middle, Maiden Surname) Be Jerone Christopher Catherine Frank 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W Davis (Husband) 8411 D Nunley Drive Baltimore, Maryland 21234 20b. Pieca of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Buriel 2 Cremation 3 Removel from Steta 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery January 7, 2000 Baltimore, Maryland 22. Name end Address of Facility 21. Signeture of Funeral Service Licensea Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23e. Part1. Enter the disease or complications that caused his deeth. Do not antar the mode of dylng, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel Can Cer disaasa or condition resulting in daath) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by Pancrestitis 1 Yes 2 No 3 Probably 4 Unknown Records, þ Pankirson! discore Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy performed? 1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 2 1 Yes 2 ILNe Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Maturel 5 Pending death. 1 Yes 2 No Investigetion 2 Accident s after death 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) In by t 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral DI completely filled in 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

KoulI

M.D

32. Register's Signeture

FAHED

31. Dete filed (Month, Dev. Year) JAN 2 1 2000

D48271

7600 osler Drive suit 411 Towson, MD 21204

DHMH 16 Rev 6/95

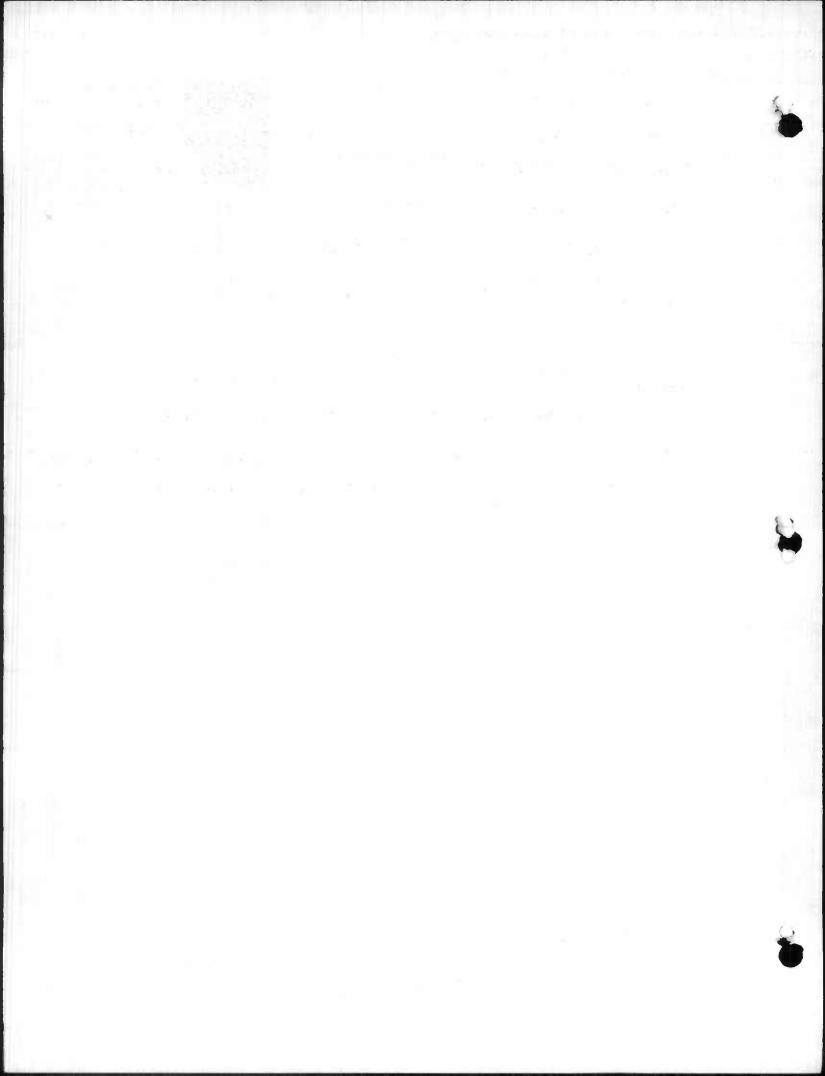
State Registrar Lette Joseph Chance

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Fannie Doelle Day O O OYear Jan 19 10:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Examiner Dundalk Genesis Eldercare If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Sociel Security Number 8. Dete of Birth May Pear) 1904 9. Birthplece (State or Foreign Country) Md. 7. Age (In yrs. last birthdey) **Funeral** Deys 1□ M 2 KF 95 213-74-4701 Yrs. Director Usual Residence of Decedent the Maryland 10b. County Baltimore 10a. State Md 10c. City, Town or Location Dundalk 10d. inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Mentel Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, he Medical Examiner must be notified at once. 1 Yes 2 No Directo 10f. Zip Code 21222 10g. Citizen of What Country? 10e, Street and Number USA 308 Oakwood Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ♠No If Yes, Give Yeer or Dates: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Julia Shepler John Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Oakwood Rd. Dundalk, Md. 21222 19e. Informant's Name/Relationship (Type, Print) Edna Ludloff Daughter 20b. Place of Disposition (Name of competeny, cremetory or other place)
Balto. Nat 20a. Method of Disposition 20c. Location - City or Town, Stete Jan 24 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Md. 22. Name and Address of Fecility Connelly Funeral Home of Dundalk, P.A. Md. 21222 7110 Sollers Point Rd. Dundalk, 23a. Part1. Enter the disease or complications that caused the death on not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death2 signed by 1 Yee 2 No 3 Probably 4 Onknown by 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 2 0 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this carifica Be 25. Was case referred to infedical 26. Piece of Peath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 L 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Placa of injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide n 24 hours af Ne Funeral Di oletaly filled in edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 208358 B& CTIMORE MALYCARD 21254 Name end address of person who completed cause of death (Item 23a) (Type, Print) 703 P4 Ri. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

Registra

JAN 2 1



8 Records, P.O. Division of Vital

altimore, Maryland 21215-0020

filed within

Hospital 24 hours a 24 hours To the within 2

Registrar

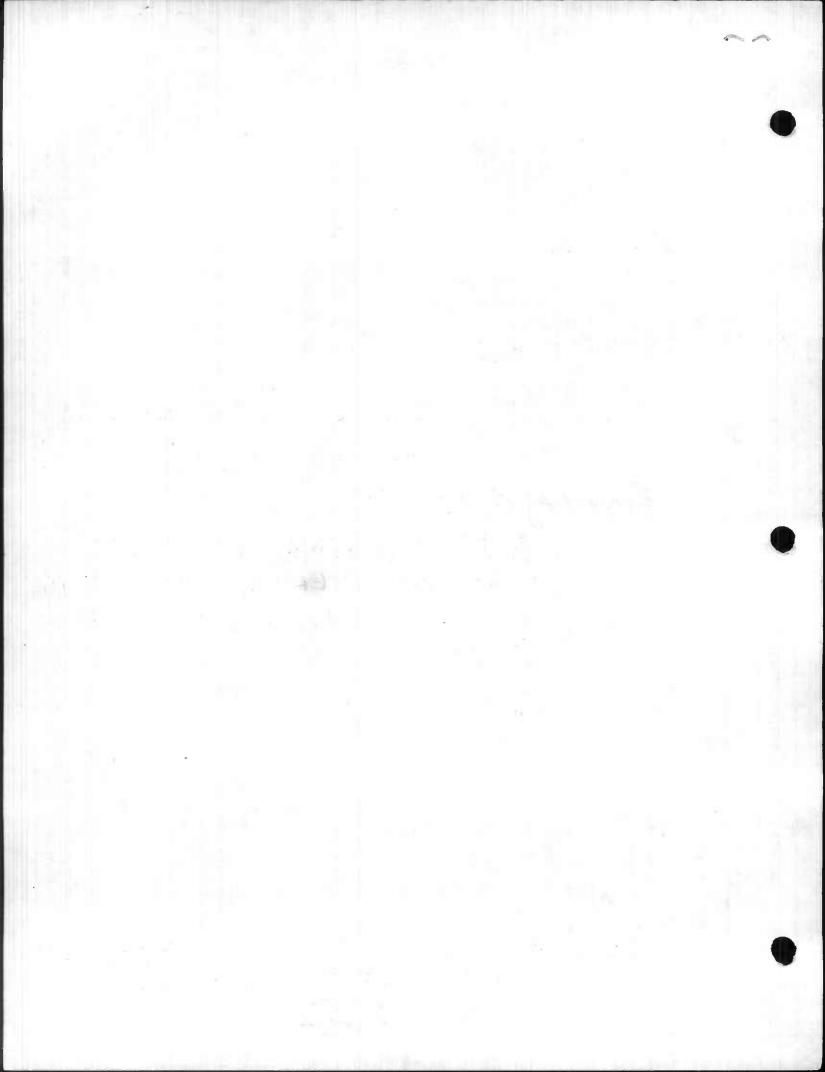
31. Date filed (Month, Day, Year)

JAN 2

Name and address of person who completed cause of deeth (Item 23a) (Type, Print I TCH (E HIGHWAY BALTIMORE, MARYLA 32. Registrar's Signeture Denistas

JANUARY 17, 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Lucille Davis Jan. 2000 11:00am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1003 North Gay Street Apt.#302 Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth Birthplace (State or Foraign Country) **Funeral** 10 M 20 F Months Davs Hours 80 215-24-1947 Yrs. VA Director Usual Residence of Decedent the Maryland permit. Peges 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show such injury or other treumstic event, the Medical Examiner must be nounsed at obta. 10a Stata 10h Counts 10c. City. Town or Location 10d. Insida City Limits Xas 2□ No MD NA Director Baltimore 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 N. Gay Street Apt. #302 21205 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yas No Il Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black à 3 Widowed WDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Custodian School System 9thGrade 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Willie Davis Luvinia Greenaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Gladys W. Perkins 36 James River Junction Emporia, VA. 23847 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal Irom Stata 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 01-21-2000 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Baltimore, Maryland 21202 less Court WM.C.March FH 1101 E. North Avenue 234. Part1. Enter the disease, or complications that edised the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart lailure. Lin only one cause of each line. Approximata Intarval Batween Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical week Examiner Due to (or as a consequence of): Examiner attending physicien end for use as the buriel-transit The law requires that the death certificeta be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 6 1 Yaa 2 No 3 Probably 4 Unknown Tai Records, à 24b. Wara autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy 788 1□ Yes 2DNo 1 ☐ Yes 2 ☐ No certificete Venous Stasis ulcero hronic of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death ne Hospital or Attanding Pi n 24 hours after death. The Funerel Director: After the pletely filled in by the funera Certification: 28c. Injury at 28d. Describe how Injury occurred Division 5 Pending investigation 1 Matural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28e. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in edical 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 16 Rev 6/95

M. Vargo

200

29b. Signature and title of certifier

30. Name and address of pe

31. Data filed (Mortal Day, Year)

Edith

1000 E. Eagh St.

rson who completed causa of death (tem 23a) (Type, Print)

MID

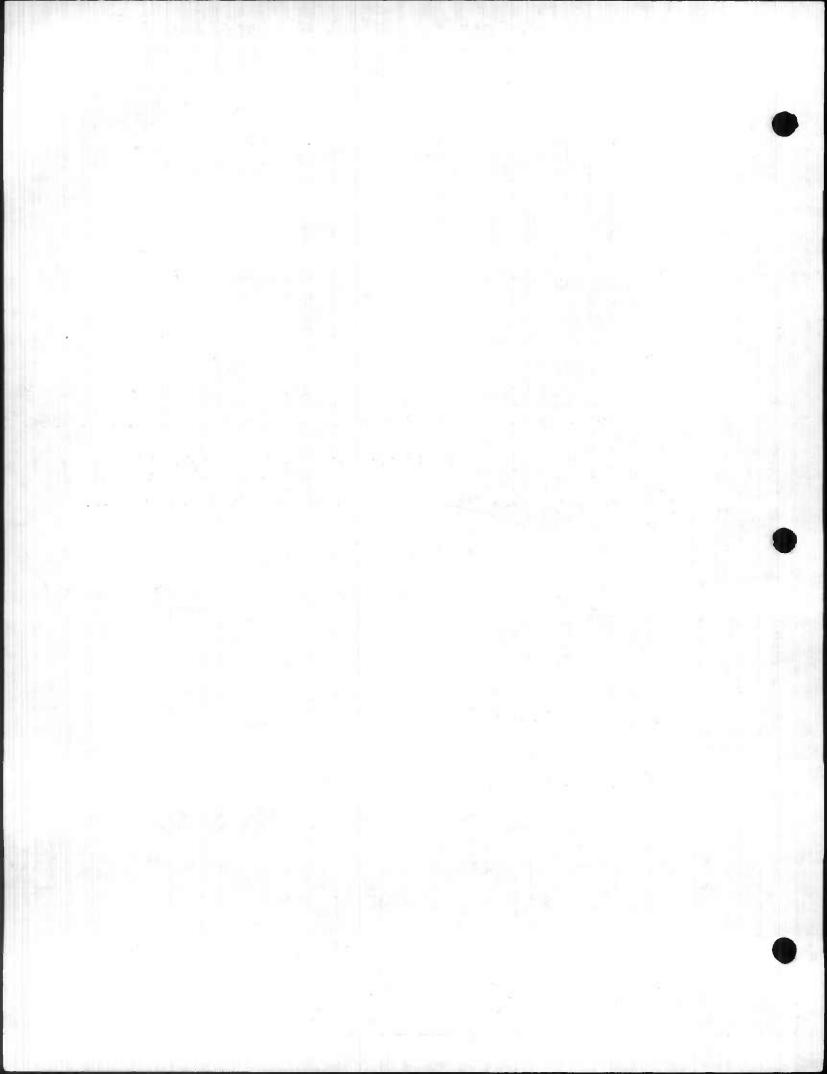
32.4

29c. License number

D507

29d. Data signed (Month, Day, Year)

Chmore MD 21202



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** NHOL CODD 5:35PM 01 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Home Baltimore 8. Date of Birth (Month, Day, Year) Feb. 28, 1911 7. Aga (In yrs. last birthday) If Under 1 Year Months Days If Undar 24 Hrs. Hours Min. 5. Social Security Number Birthpleca (Stete or Foreign Country) **Funeral** 10M 20F 220 05 0206 88 **Director** Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner roust be notified at No Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death v. Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 28a and Injury or other traumatic event, the terms. 5603 Roland Ave. 21210 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yaar or Dates: 1941–45 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Executive Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donohue Regina 2 Terrance 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5210 Patterson Farms Road John C. Donohue, Jr. (son) Baldwin, Maryland 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 1-24-2000 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensas 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Limit only one cause on each line. Baltimore, Maryland 21212 Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical scute Bacterial presumic **Examiner** Due to (or as a consequenca of) Completed by Physician/Medical Examiner luen 2A physician and the burial-transit bye to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown and dementin Records, 24b. Were autopay findings available prior to completion of causa of death? 24a. Wes en eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Gursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury et Work? or Attending 1 Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 24 hours after death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end manner stated. 29a. Certifier Medical To the Fune complately f (Check only one) To the Within 2 29b. Signature and title of certifier wo led ceuse of death (Item 23a) (Type, Print)

State Registrar

JAN 2 1 2000

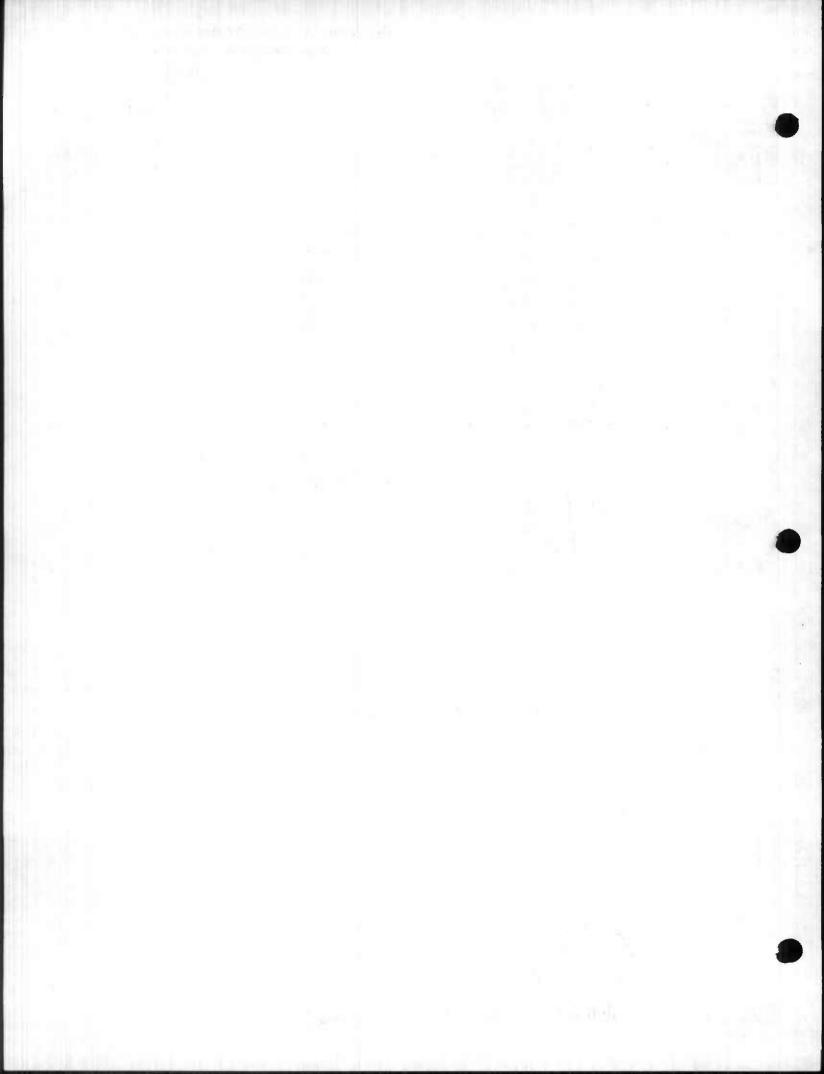
32. Registrar's Signature

J. Sparks

DHMH 16 Rev 6/95

Donohae

NHQ



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 01333

	Certificate of Death		Reg. No.	01333								
Physician	Decedent's Name (First, Middle, Last) Louis Carter Elseroad	2. Date of Do	Day Y	3. Time of Death 4:48 am								
/Medical Examiner		Jan. 20,2000 4 4b. City, Town, or Location of Death Owings Mills Baltimore										
Funeral Director	5. Social Security Number 218-14-3190 6. Sex 1	8. Date of Bi (Month, Di July 1	ay, Year)	Birthplaca (State or Foreign Country) Maryland								
r show adult	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. Baltimore Owings Mills			10d. Inside City Limits 1 ☐ Yas 2 1 No								
liams 23s or 28s-f shoner must be notified at unersi Director	10e. Street and Number 15 Phlox Circle E 15 10l. Zip Code 21117		10g. Citizen of What Country?									
ar, or here 23 Examiner must by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Never Married 2 Newried 1 Never Married 4 Divorced 1 New Sive WW II 1 Yes 2 No Specify:	13. Was Decedent of Hispanic Origin? (Specify Yes or Nil Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:										
ygene. er than 'natur r, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	orking	16b. Kind of Business/Industry Giant Foods									
B very	17. Father's Name (First, Middle, Last) 18. Mother's Name	18. Mother's Name (First, Midd										
aumatic a	19a. Informant's Nemer/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or F	V. Garb		ete, Zip Code)								
if Item 27 or other tr	Ida Mary Elseroad - Wife 15 Phlox Circle E 15, Owings Mills, Md. 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) St. Thomas Church Cem. Jan. 22, 2000 Owings Mills, Md.											
by the attending physician and important important and properties and important and properties are the burst-transft and in portant and in portant. Answering hysician/Medical Examiner	21. Signature of Funancial Service Uconsee 22. Name and Address of Facility Eckhardt Funeral 11605 Reisterstor 11605 Reisterstor 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart taiture. List only one cause on each line. Immediate Causa (Finel disease or condition resulting in death) Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	an Rd., ac or respiratory in AuroAic	errest,	21117 11s. Md. Approximate Interval Between Onset and Deeth Onset and Deeth Interval Between Onset								
5 A	Sternal fracture (12/99)		Yes an autopsy 24b. Were autopsy findings									
shou ete		perl	ormed?	available prior to completion of cause of death?								
rector, page 2 Be Comp	25. Was case referred to medical 26. Place of Death (Check only one)											
ther death. Sheetor: After this in by the funeral di artification: To	axaminer? 1 Yes 2 No											
hou hou	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Within 24 To the P. Computer	29b. Signature and title of certifier Dubouh Mous WO 29c. License number D31364	1	29d. Dete signed (Month, Dey, Year)								
ME	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 Crossroads W. #250 Owngs Mills Mills	211	17									
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatura JAN 2 1 2000 Server Saparlis											

T & LITEL 127 20.31-1 of the same a district of the same of the contract of the same of the contract

116 to the term of the 111, 11.

. 0

1001, 11

Addition to the day

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 18 2000 5:40AM John Paul Eckenrode, Sr. 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1X) M 2 F Months 215-14-7914 December 24, 1919 Maryland Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Baltimore Ruxton 10f. Zip Code 10a. Street and Number 10g. Citizen of What Country? 6 Roland Court 21204 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: WWIT 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive +1 General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Ernest Gregory Eckenrode Viola Fick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Doris Catherine Eckenrode/ Wife 6 Roland Ct. Ruxton, MD. 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 1-21-2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 an or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cardiac or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28h Time of 5 Pending 1 Yes 2 No 2 Accident

Examine physician and s the burial-transit The law requires that the death cartificets be assouted Box 68760 Physician/Medical for use as Records, P.O. signed to by Completed Division of Vital or Attending Physician: Be Certification: To this .

Physician

/Medical

Examiner

Director

Funeral

4

Completed

89

Funeral

Director

288-7

'natural', or hama 23a or

the Maryland

72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Nem 27 is marked other i

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. Medical

State Registrar

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number

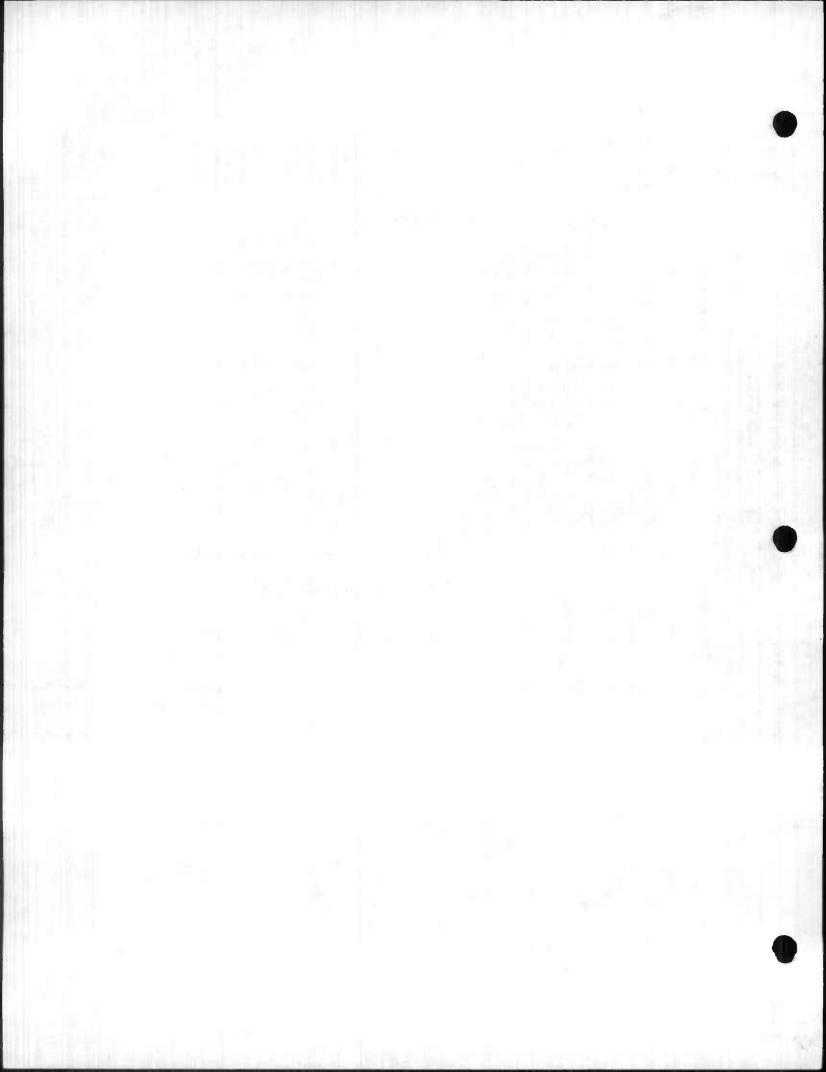
29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ed cause of death (Item 23a) (Type, Print)

32. Retristu



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Martha Tourison Eddleman January 19 2000 7:45 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Anne Arundel Severna Park Heartlands Severna Park If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours Pennsylvania 1□M 2□F Yrs. 186-03-4670 May 13,1915 Director Usual Residence of Decedant with the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow must be notified at 1 ☐ Yas 2 No Directo Anne Arundel Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 715 Benfield Road 21146 USA Herna 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, 12. Was Decedant Evar In U.S. Armed Forces? 11. Marital Status than "natural", or item the Modical Examiner Bleck, White, etc. filed within 72 hours after 1 ☐ Yas ② XNo If Yas, Give 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 XNo Specify: White Specify: Aq 3 Widowed 4 □ Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry lei Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Peges 1 and 2 should be file.
Department of Health and Mentel Hyg.
Important: If Item 27 Is marked other any injury or other traum-17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Surgeme) Sedgwick Tourison Martha Downey 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan E. Finerty (Daughter) 1841 Northridge Lane, Annapolis, MD 21401 Baitimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/24/ 1 Burial 2 Cremation 3 Removal from State West Laurel Hill Cemetery 2000 Bala Cynwyd, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Hardesty Funeral Home, P.A. Kulla niche 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Alzebreimers disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the Due to (or as a consequence of): 8 080 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown 1+ 7 W Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an eutopsy performed? certificate has **page 2** 1 Yes 2 9 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 89 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 PNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. Medicai 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 1/19/2000 + M. Gue 026373 30. Neme and address of person who completed ceuse of freth (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

oll

JAN 21

31. Date filed (Month, Dey, Year)

806

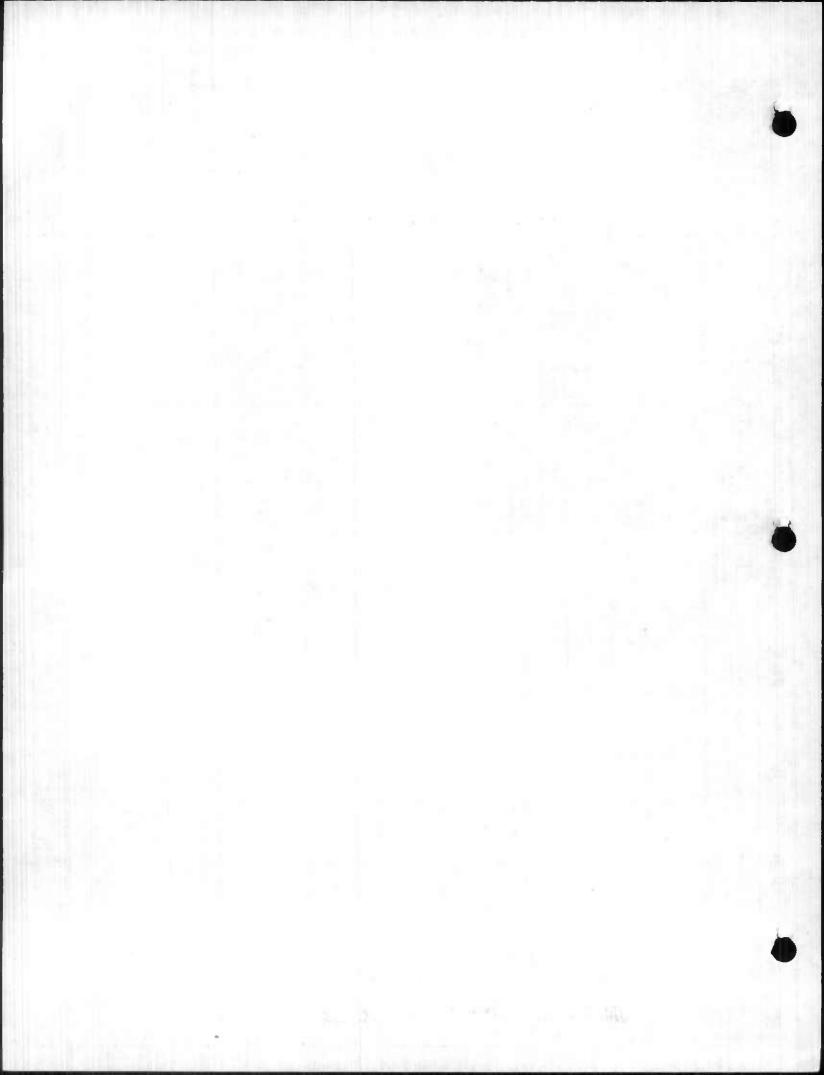
2000

news

32. Registrar's Signatura

Ps (

ORIGINAL

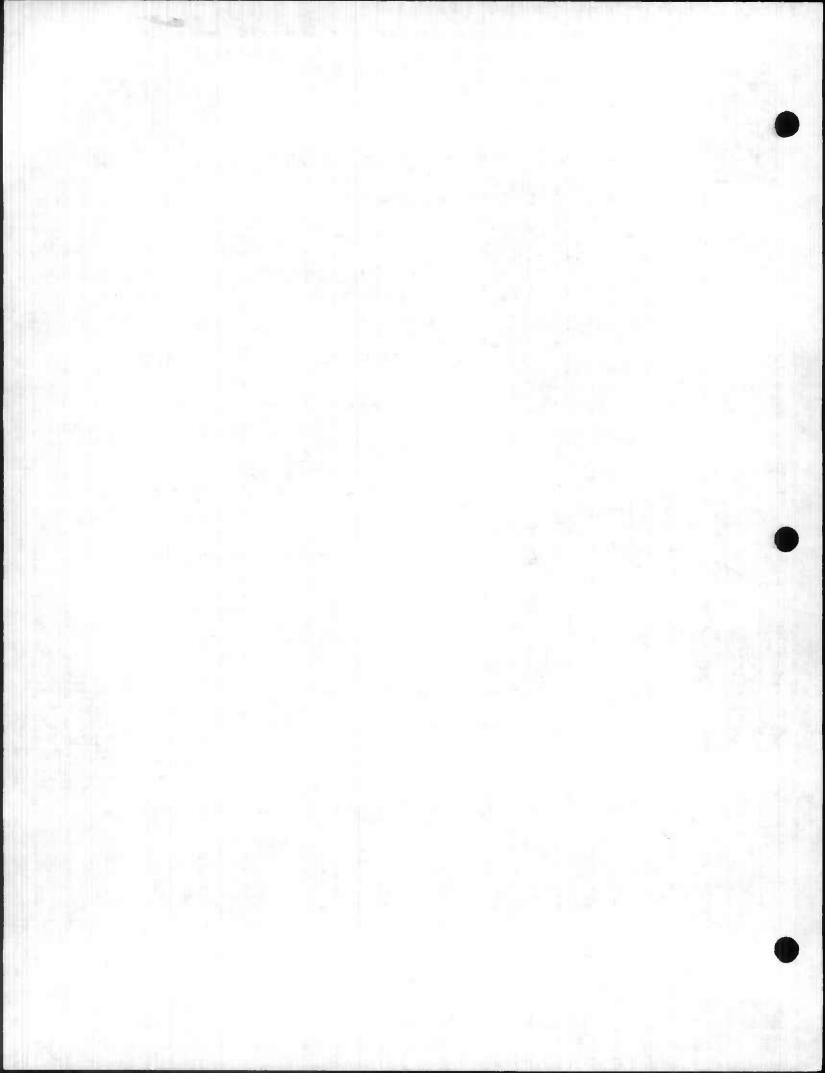


Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 01336

					Cer	tificate of	Death			Reg. No.			
	1. Decedent's Name (First, Mi	ddie, Last)						2	. Date of De Month	ath Day	Year	3. Time of Death	
cian lical	Cristian Fotescu								JANUAI			1744 PM	
	4e Facility Name (If not institution, give street and number) 2031 PAULETTE ROAD APARTMENT # 204 4b. City, Town, or Lo								4c. County of Death BALTIMORE		RE		
	5. Social Security Number	6. Sex	11.190 (11.)101 1001 010101/			If Under 1 Year Months Days	If Under:	24 Hrs. 8	Dete of Bir (Month, De	th Year)	9. Birth	place (State or Fore	
	n/a	1 12 M 2	M 2□F 74			WOTHING Days	Hours		-27-			ania	
3-	Usual Residence of Decedent 10a, Slate 10b, Cou	ntv		10c City	Town or Lo	cation						10d. Inside City Lim	
	10e. State 10b. County 10c. City, Town or Location Dundalk									1 ☐ Yas 2 ☐			
-	10e. Streel and Number 10f. Zip Code							10g. Citi			itizen of What Country?		
	2031 Paulet		21222				Romania						
	11. Marital Stetus 1 □ Never Merried 2 □ Merried 1 □ Never Merried 2 □ Merried 1 □ Yes 2 ☑ No			es?	n U,S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ₺ No Specify:			gin? (Speci , Puerto Ri	fy Yes or No can, etc.)		ck, White,	American Indian, White, etc. White	
	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:					is to sell to opoury.				Specify	y: W.II .	ıte	
-	15. Deced	16a. Deced	Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry						
	Elementery/Secondary (0-1)	2) Co	College (1-40/5+)			Give kind of work done during most of working life. DO NOT use retired)							
-		3			Supervis		,		Produce				
	17. Father's Name (First, Midd						18. Mother's Name (First, Middle, Meiden Sumeme) Maria Osmann						
-	Victor Foto										St. / =	0.41	
	19e. Informent's Neme/Relation		int) da	ughter									
-	Roxann Kowa	alski		20h Ble	2031	Paulet sition (Name of	te R	d. A	pt. 2	20c. Location	more,	Md. 21222	
	20a. Method of Disposition 1 ☑ Burlal 2 ☑ Crematic	n 3 Remov	el from St	ate Ce	metery, cren	natory or other pla	ce)	1/20					
	4 □ Donetion 5 □ Other (Specify) Oaklawn 1/22/2000 Baltimore,								-				
	21. Signature of Funerel Servi	ce Licensee 9 Zayı	~	/		Name end Address S. Conkl							
+	23a. Pert1. Enter the disease	//	100	٧				41		700.04	1	Approximete	
edical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c			es a conseq								
3		d											
Physician	Part II. Other significant cond	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did	Did tobacco use contribute to the cause of de			
E								1 🗆	1 Yee 2 No 3 Probably 4 Unit				
AG DA									24a. Was	a. Was an autopsy parformed?		Vere autopsy findin	
100									part	ormed?	0	vailable prior to ompletion of cause f death?	
Completed									LINS	Yes 2 No	1	☐Yes 2☐ No	
	5. Was case referred to medical 26. Place of Death (Check only one)									D 163 2D 160			
ופ	examiner? 10Xes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 XXesidence 6 Other (Specify)									ih)			
- To	27. Manger of Death	288	a. Dete of	tnjury	28b. Time of					how injury occu		.,,,	
at lo	1 Neturet 5 Par 2 Accident inve	estigetion	(Month,	Day Year)	Injury		Yes 2	No					
Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office 28								28f. Location (Street and Number or Rural Route Number,				
5	4 ☐ Homicide building, elc. (Specify) City or Town, State)												
edical	29a. Certifier (Check only one) 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, dale end pleca, and due to the cause(s) and manner es stated. 2 Middleal Examiner: On the basis of axaminetion and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated.												
	29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Yea												
	Mounts methall of O.C.M.E.								JANUARY 21, 2000				
-	30. Name and address of pars	on who complet	ed cause	of death (Item	23e) (Type	Print)							
	HA Gram		Contr			Street, E	Baltim	ore,	Maryla	and 2120)1		
ate	31. Date filed (Month, Day, Ye			gisfrar's Signate					1				
e Ir	י ואמו			heneva	1 9	1000	is.						

DHMH 16 Rev 6/95



William

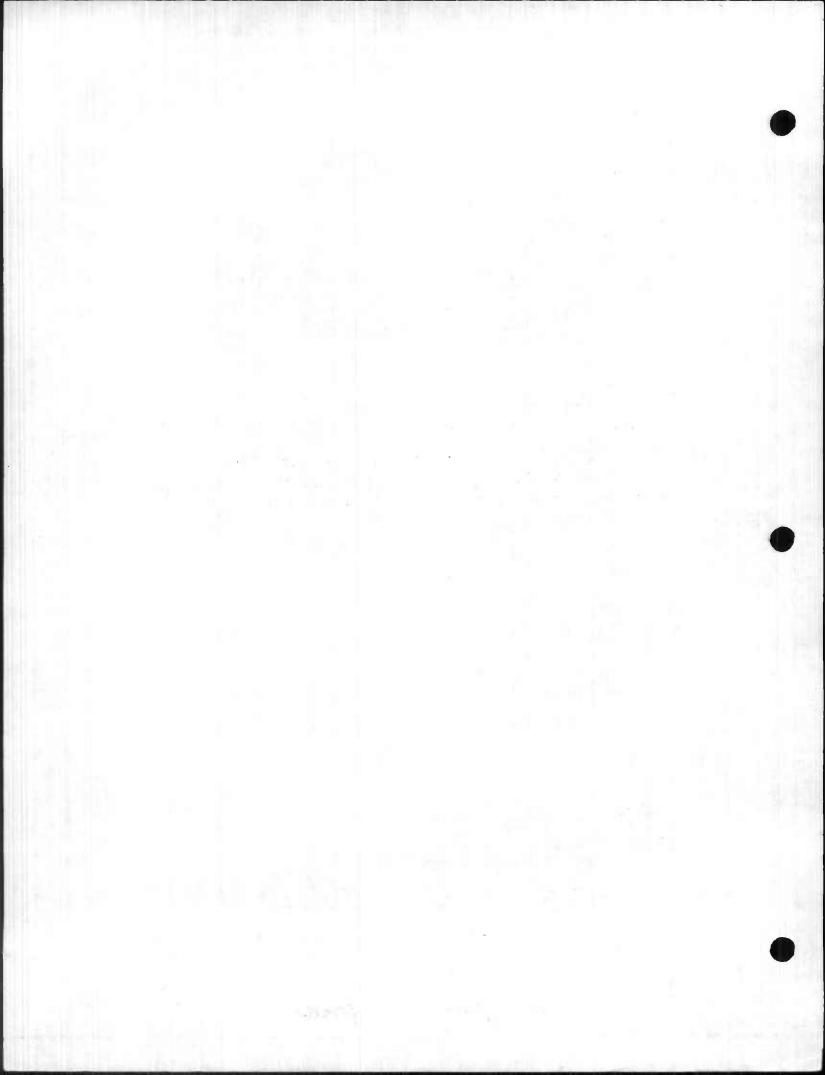
Fusting

Baltimore, Maryland 21215-0020

Division of Vital

To the P within 2 To the F **DHMH 16 Rev 6/95**

Physician WILLTAM /Medical 4a Facility Name (If not institution, give street and number) Stella Maris 5. Social Security Number **Funeral** 199-03-3909 Director Usual Residence of Decedent r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at Director Md. 10e Street and Number 105 Kenilworth Park Dr. Apt. Funeral 1 Never Married 2 Married à 3 ₩ Widowed 4 Divorced Completed Hygiene. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If from 27 is marked of 2 19a. Informent's Name/Relationship (Type, Print) Mr. William H. Fusting, Jr./son 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State b 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Fundant Service D 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immedieta Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last 8 Physician/Medical 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t p Completed peeu Juneral director, Be 25. Was case referred to medical 1 Yes 2N No Certification: To sk th 27. Manner of Death **SNatural** death. or Attend after death Director: / 2 Accident 3 ☐ Suicide 4 Homicide Hospital of 24 hours a
 Funeral D 29e. Certifier Medicai (Check only one) eer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(a) and manner steted. 29b. Signeture and III 29c. License number 29d. Date signed (Month, Day, Year) 1001 15504 400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTO, MI NAKHUDA 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS #2, PER PHY G799 1-21-2000 WR. Certificate of Death Reg. No 2. Date of Deeth 1-19-2000 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** BARBARA FOSTER 8:55 A.M. /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2708 THE ALAMEdA BALTIMURE 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplece (State or Foreign Country) Deys Months 1 M 2 F Hours Yrs. **Director** 43 217-68-4409 05/13/1956 Maryland Usual Residence of Decedent with the Maryland i show 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner rount be notified at Y□ Yes 2□ No Directo Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2708 The Alameda 21218 Funeral U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indien Bleck, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Day Care Provider Child Care other treumstic event, 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Melden Sumeme) Pages 1 and 2 should be fit ment of Health and Mentai Hant: If Item 27 is marked out Be Thomas Foster 2 Carrie Redd 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Foster/Mother 2708 The Alameda, Baltimore, Maryland 21218 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 0 permit. Page Department of Important: If any Injury or Zion Cemetery 01/22/00 Landsdowne, Maryland 21. Sonature of Funeral Service Licer 22. Name end Address of Fecility Derrick C. Jones Funeral Home Baltimore, Maryland, 4611 Park Heights Ave. 21215 het a used the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and a sch line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ceuse Approximete Interval Between Onset end Deeth **Physician** nonno de ticura Syn done Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. 8 an/Medicai Due to (or as e consequence of): guip use Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobecco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed t Records. by 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24e. Was en eutopsy performed? Completed page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4□ Nursing Home 5 ☐ Hesidence 6 □ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Beath 28d. Describe how Injury occurred Certification: 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide edical 1 🕒 CertifyIng Physicien: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. 29e. Certifier (Check only 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29th Signature a

impleted cause of deeth (Item 23e) (Type, Print)

e F S T
32. Registrer's Signeture

655

3ACTIMURE

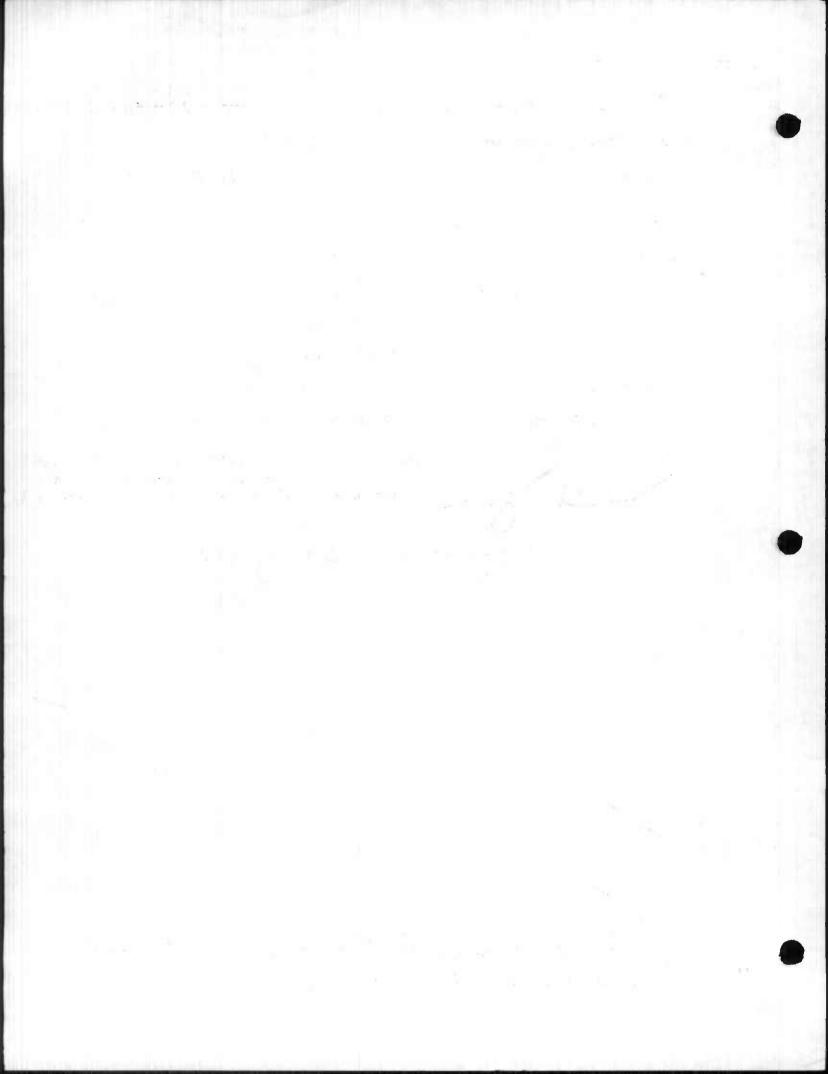
AH

DHMH 16 Rev 6/95

State Registrar

MES 0 0 201

3



DHMH 16 Rev 6/95

110 ----James 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death JAN. Dey 2000 ear **Physician** 14, FRANK J. GABINET 9:12 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) NOV 8, 1930 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 100M 20 F 69 Yrs. 170-24-1736 **Director** MD. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD. DUNDALK 1 ☐ Yaa 2 No Director 28a-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be n 101 CENTER PLACE, APT. 511 21222 Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. Heres 2 No UKN.
If Yes, Give
Yeer or Detea: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINST 8 MACHINE SHOP 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) ould be fi Mental P JOHN GABINET ANNA SOMMERS 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21222 19e. Informant's Neme/Relationship (Type, Print) DOROTHY GABINET/WIFE 101 CENTER PLACE, APT 511, BALTIMORE, MD. Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date permit. Pages Department of h ND Burial 2 ☐ Cremetion 3 ☐ Removel from Stete
4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEMETERY1/22/00 BALTIMORE, MD. 22. Name end Address of Facility CHARLES S. ZEILER & SON, INC. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. MD. 21224 Zsa. Part1. Enter the diseas shock, or heart failure. Approximata Interval Between Onset end Death Physician Concer Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be axecuted the burial-trans Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 ☐ Yea 2 ☐ No 3 Probably 4 ☐ Unknown ata has been signed page 2 should be de 2 Records, Be Completed 24b. Were autopsy findings evallable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificata of Vital or Attending Physician: 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Mother (Specify) HDS Proc Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 5 Pending investigation 1 Natural e Hospital or Attending 124 hours after death. e Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a, Cartifier Scertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. within 2 \$ 29c. License number 29b. Signeture and title of certifie ny

State Registrar

31. Dete filed (Month, Day, Year)

JAN 2 1 2000

32. Registrer's Signer

JAN 2 1 2000

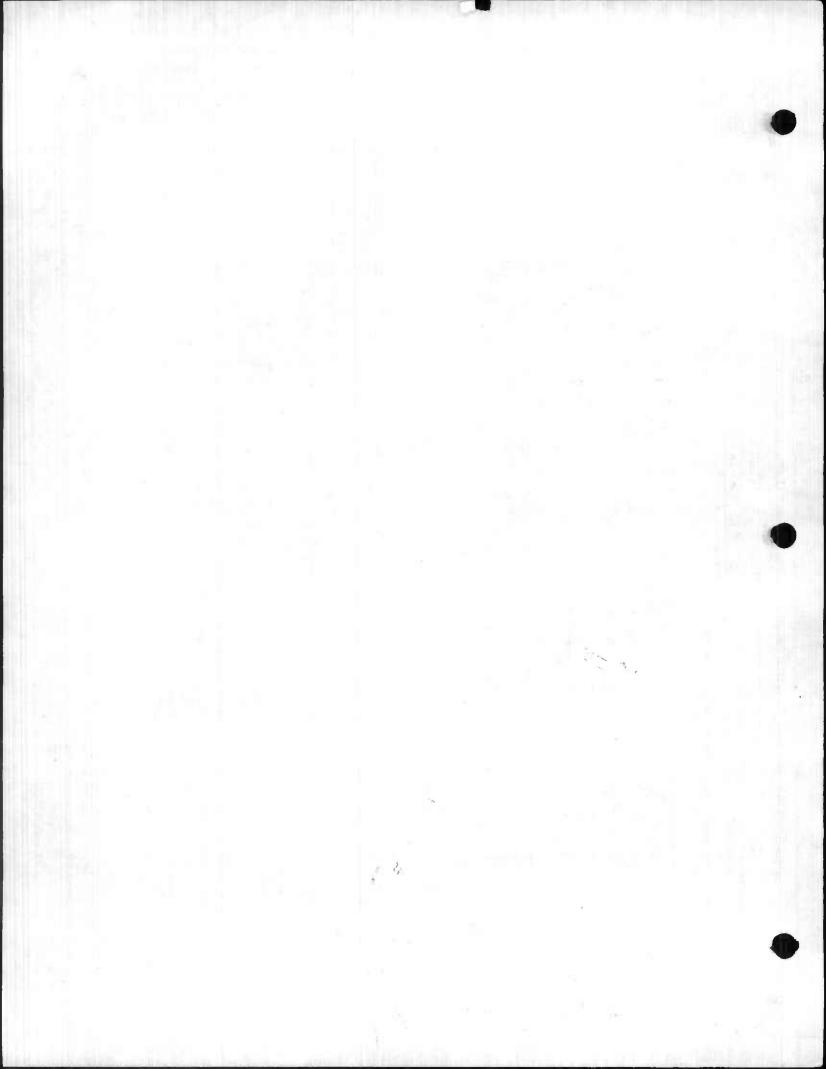
32. Registrer's Signeture

d cause of death (item 23a) (Type, Print)

G. Spark

le S. Balto, md Eczex

Meson 14



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth WESLEXGARRISON Month 15000 7:41 AM DANUARY 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SAMARITAN HOSPITAL BALTIMORE CITY BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Day, Year)

O 4 0 4 1 9 0 5 6. Sex 1 M 2 □ F 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Months 9.4 221-09-017 Yrs. Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits TURNERS STATION MD BALTO. 10 Yes 20 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 303 SOLLERS PT. RD. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, Whife, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify:BLACK 3. Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) REFINING CO. LABORER 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) THOMPSON **EMMA** CHARLES GARRISON 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 303 SOLLERS PT. RD. BALTO., MD 21222 HILDA FAISON/DAUGHTER 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremetion 3 Removel from State BALTO., MD. KING MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 25/2000 21. Signature of Funerel Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC mes U. 1701 LAURENS ST. BALTO., MD. 21217 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, and of, or heart failure. List only one cause on each line. Approximete totervai Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) SEPSIS 2 WEEKS Due to (or as a consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es e consequenca of) Pert II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END-STAGE RENAL DISEASE 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy HYPERTENSION 2 No 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) TV Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28d. Describe how tnjury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 11402 TANUARY

that the death certificate be executed Box 68760. Records, P.O. à peed Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, within 2 ş

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Examiner

Physician/Medical

b

Completed

B

2

Certification:

Medical

Funeral

Director

r is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

should be filed within 72 hours after ond Mental Hygiene.

marked other than "natural", or ite

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If itam 27 is marked oths any Injury or other traumatic event

Physician

/Medical

buriel-transit

980

and

physician as the buriel

Examiner

Baltimore, Maryland 21215-0020

the Maryland

death

State Registrar 31. Dete filed (Month, Dey, Year) JAN 2

30. Name end eddress of parson who completed cause of death (Item 23e) (Type, Print)

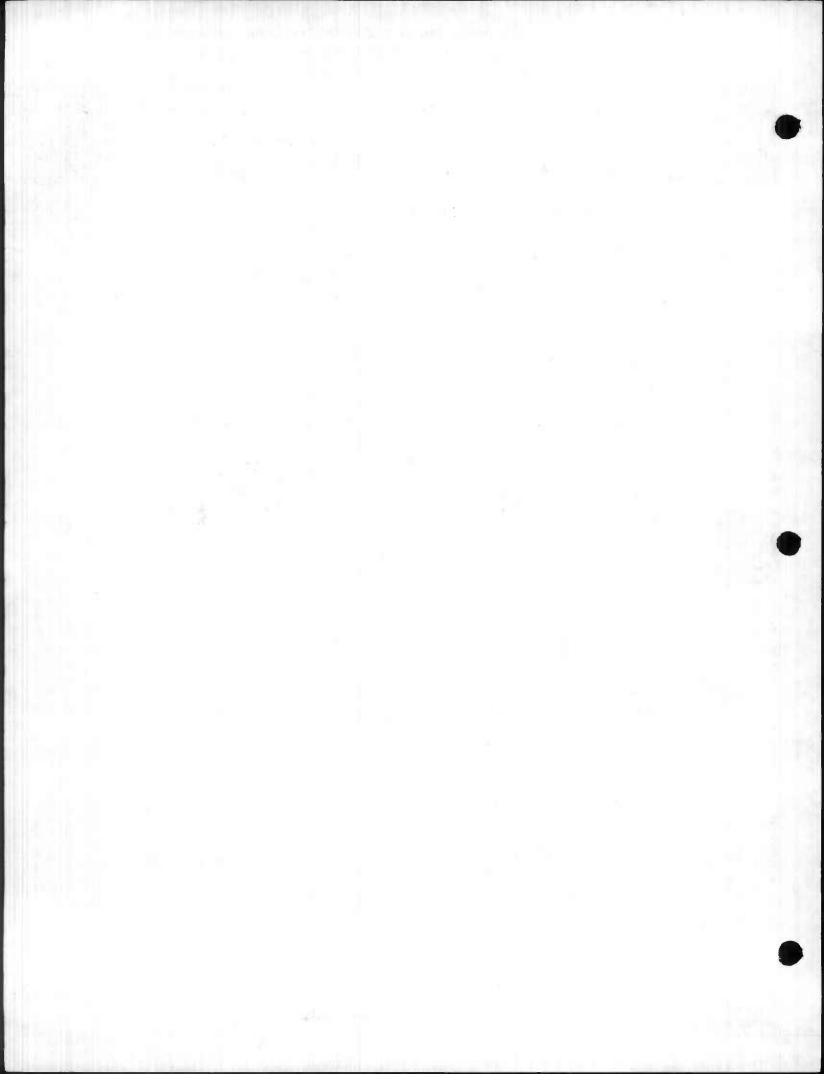
32. Registrar's Signature

2000

WILLIAM IMBEAH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD,

BALTIMORE, MD 21239

DHMH 16 Rev 6/95

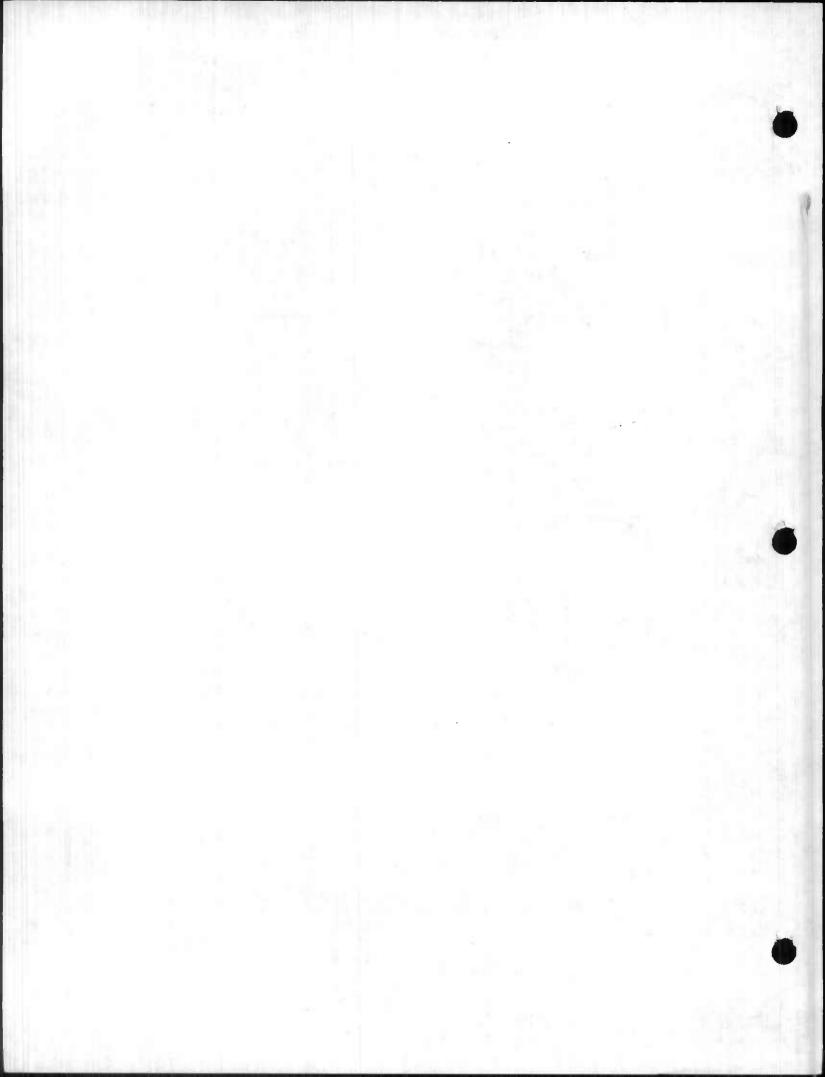


Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		Reg. No.	0 01342							
hysician /Medical	Decedent'a Name (First, Middle, Last)	2. Date of De Month	ath Day	3. Tima of Death							
	Mildred C. Gorman	Januar									
xaminer	4a Facility Name (If not institution, give street end number) 4b. City, Town,	or Location of Deat	-								
	1910 Heathfield Road Baltin	more		N/A							
neral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Months Days Hours N	Hrs. 8. Dete of Bir Min. (Month, Da	th Year)	Birthplece (State or Foreign Country)							
ctor	215-09-5576 1 M 201F 82 Yrs. Months Days Hours	May 31	, 1917	Maryland							
	Usual Residence of Decedent			and total on At to							
	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 11 Yes 2 □ No							
S	Maryland N/A Baltimore			VEITES 2LINO							
ef, or teme 23s or 28s-f show Examiner must be notified at by Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?								
	1910 Heathfield Road 21239		United States								
	11. Maritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pu	(Specify Yes or No	or No- 14. Rece - American Indian, Black, White, etc.								
F	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify		Specify								
J D	3 LAWidowed 4 Divorced Year or Dates:		Оросиј	White							
) je	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	working	16b. Kind of Business/Industry								
npidu	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+)										
traumatic svent, the Medical	12 Homemaker			vn Home							
	17. Father's Name (First, Middle, Last)		dle, Meiden Sumeme)								
2	Frederick James Conrad Glad	ys Marga	ret 511	ison							
	19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or										
	Mrs. Elise G. Benser/ Daughter 1910 Heathfield Road	1	Baltimore, MD 21239								
	20a. Method of Disposition 1	Dete		City or Town, State							
	4 Donatton 5 Other (Specify) Parkwood Cemetery	1/22/200	00 Bal	timore, Maryland							
	21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Name end Address of Facility		5305 H	arford Road							
eny Injury	Miach LEONARD J. RUC	K. INC.	Baltimo								
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as care			Approximate Interval Between							
in	shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth										
	Immediate Cause (Fine)			100-							
dical niner	disease or condition resulting in death) a. Cucuc CC MY/LST 100ay										
	Due to (or as a consequence of):										
늍	Sequentially list conditions b. Due to (or es aconsequence of):	sease		syears							
Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	CL.	2								
	11/61/11/11/11/11/11/11/11/11/11/11/11/1										
edical	that initiated events resulting in death) Last Due to (or as a consequence of):										
\$	d										
8		ant Dis	A. b								
d be detached for us d by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contributs to the cause of death?								
	Carleman's Disease	1	1 Yes 2 No 3 Probably 4 Unknown								
d by		244 900	24a, Was an autopsy 24b. Were								
page 2 should Completed	STROKE		performed? eva								
du				of deeth?							
Co		10	Yes 25 No	1 ☐ Yes 2 ☐ No							
ê	25. Was case referred to medical assemble 26. Place of Death (Check only one)										
2		ng Home 5 Ples	idence 6 Oth	ier (Specify)							
	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d Describe	how injury occur	red							
atio	1 SNatural 5 Pending (Month, Day Year) Injury Work/ 2 △ Accident investigation M 1 ☐ Yes 2 ☐ No										
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
F	a Champing and Cabacity	Only of 10	Only or rown, State)								
-	29a. Certifier 129 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pl										
edical	(Check only and the basis of examination and/or investigation, in my opinion, deeth of end manner stated.	occurred at the time,	date and place,	and due to the cause(s)							
×	29b. Signature and take of continer 29c. License number	/	29d. Date signe	d (Month, Day, Year)							
	1/201/MIN D.723	34	34 Jan. 19. 2000								
108			BOOK	110 21211							
1	30. Metroe and address of person who complained cause of death (flem 23a) (Type, Print)	. 1.	CL	un 212/1.							
	31. Data filed (Month, Day, Year) / 32. Redistar's Signature	my rue	oute	200							
State	JAN 2 1 2000 Dener & South										
strar	THIN & I COULD A POLICE TO TOTAL										

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:00 PM Forrest Molan Griffin danuary 17,2000 /Medical 4a Facility Nama (If not institution, giva streat end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Square Hospital tranklin CENTER Rosedale Baltimore If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) **Funeral** Days Months 15 M 2 F Hours 80 Director 237-09-1271 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show Maryland Baltimore Essex 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ð 407 Edmunds Way 21221 U.S.A. "natural", or hams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-tf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Evar In U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No 1 Nevar Married 2 Married 1940-1 Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White 1941 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Supervisor U.S. Government Maryland 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) a 8 and Mental Whitner M. Griffin Georgia Bourne Pages 1 and 2 should ORRES 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma E. Griffin (WIFE) 407 Edmunds Way Baltimore, Md. 21221 mportant: If Isem 27 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1/20/2000 8 1 Burial 2 Cremation 3 Removal from State Baltimore, Co. Md. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 23a. Pall 1. Enter the disease, or complications and caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset and Death **Physician** /Medical Immediete Cause (Finat . Exacerbation of Chronic obstructive pulmonary disease disease or condition resulting in death) Examiner Examiner Emphysema ician and burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician at the burial Physician/Medicai Dua to (or as a consequence of) 957 Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1016 2 No 3 Probably 4 Unknown oronary artery disease signed b ρλ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1≥ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending investigation 1. Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 TYas 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edicai (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 00 Marie D2090 lias 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prive Battimore, Maryland 21237 9000 Franklin Square Marie Chatham 31. Date filed (Month, Day, Year) 32. Registrar's Signature

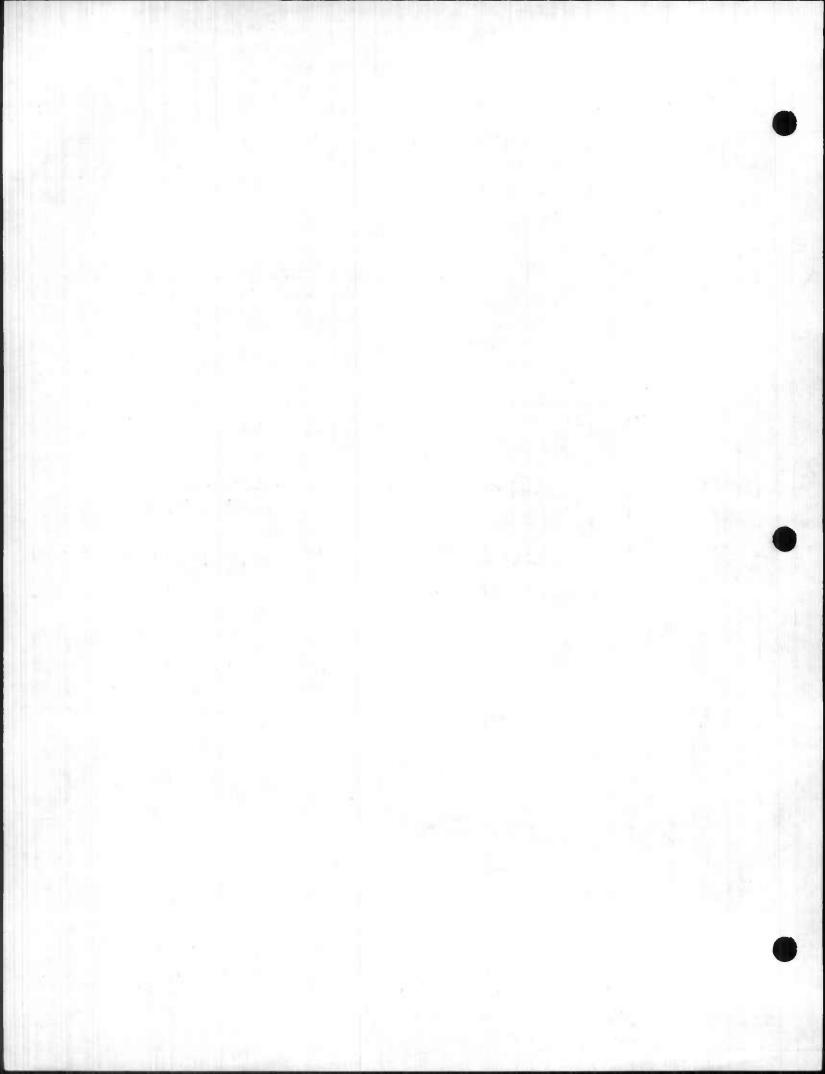
DHMH 16 Rsv 6/95

Registrar

JAN 21 2000

--- 0 0 0000

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 19, 2000 7:20 A. JANUARY В. Lizzie Green /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ■ M 2 💢 F Director 250-50-2997 0/15/1908 South Carolina **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Randallstown 1 ☐ Yes 2 XNo Directo 28s-t 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 9824 Southall Road 21133 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married natural, or 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 ₩idowed 4 Divorced 2 should be filed within 72 hou and Mental Hyglene. a merked other than "natura sumstic event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Midwife Medical 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Ceasar Grant Eugenia Best 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Cornelia L. King/Daughter 9824 Southall Rd., Randallstown, Maryland 21133 important: if Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, cremetory or other place) Cem. 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremetion 3 □ Removal from State 01/23/00 Allendale, S.C. 4 □ Donation 5 □ Other (Specify) Ervington Bapt. Church 22. Name and Address of Facility Derrick C. Jones Funeral Home 21. Signature of Funerel Service Licenses 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). Examiner umonia physicien and the burlai-transit The law requires that the death certificeta be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No of VItal Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 20 No 1) A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending Division 5 Pending investigation deeth. 1 Yes 2 No 2 Accident 24 hours after deet Funerel Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Dey, Year) 01 MO 2000 1 aurong 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 CHARLES MD 21204 STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

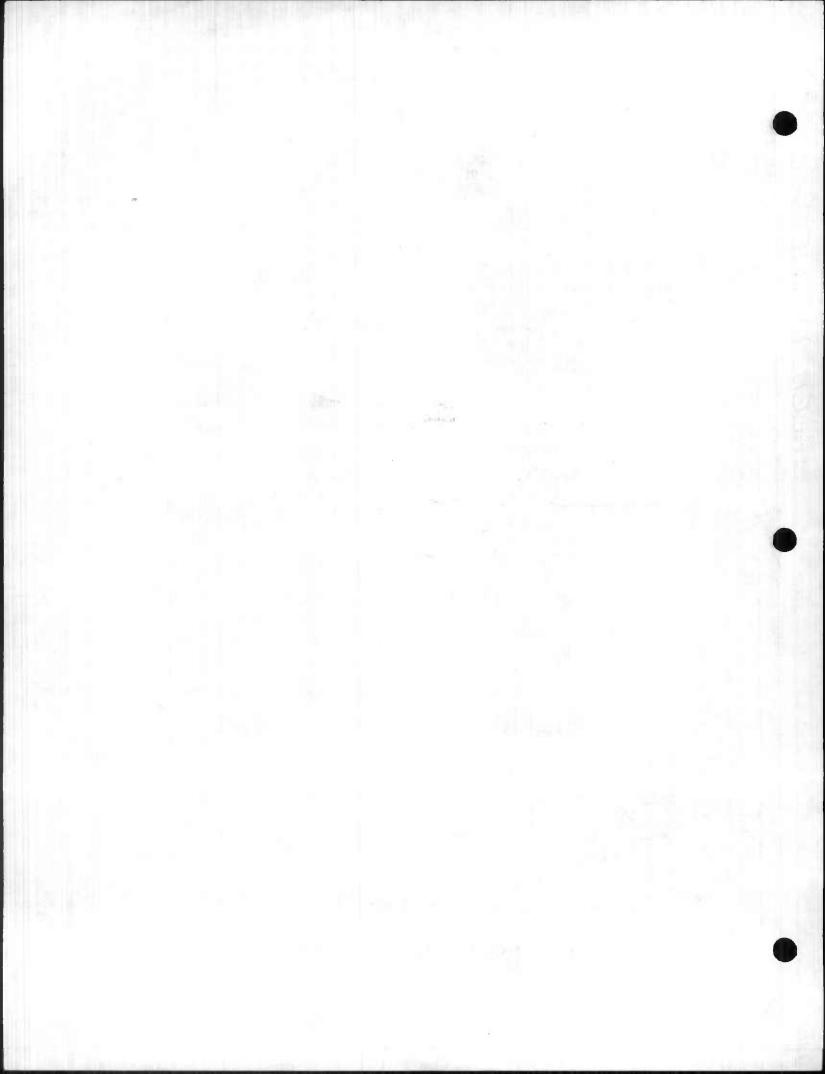
ANY

Registrar

DHMH 16 Rev 6/95

JAN 21

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items#4b,4c perPhy, Item#5 perFH G779 1/21/2000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARY GODDARD 2000 anuar 11 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health Care | Fort Washington
| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | Apr 27, 1914 Livingston P.G. 5. Sociel Security Number 3200 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country)
 DC **Funeral** 1 □ M 2 1 F 578-32-32 85 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 Yes 2√ No Director Fort Washington Prince Georges 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20744 1202 Livingston Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Eiementary/Secondery (0-12) government College (1-4or 5+) unknown secretary permit. Pages 1 and 2 should be litted in Department of Health and Montal Hygien in Proportents if I liem 27 is marked other the page. unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John Grim Mary Schwarz 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph Goddard/son 4480 Richard Lawrence Drive, Marbury, MD 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee Ronald S. Wade, Stare Andreson Facility and 655 W. Baltimore Street Director Rate 21201 Baltimore, MD nicion Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 4 hoons disease or condition resulting in death) a CARABRE UNSCULAR ACCIDENT Examiner Due to (or es a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 certificate be Physician/Medical Due to (or es a consequence of): 88 987 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Únknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peed page 2 hes 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Netural 24 hours after deeth. 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar LIVINISTON

DO 73 48

MR

Dr.

regbalo

MO

JAN 2 1 2000

8. M.NEDZBALA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

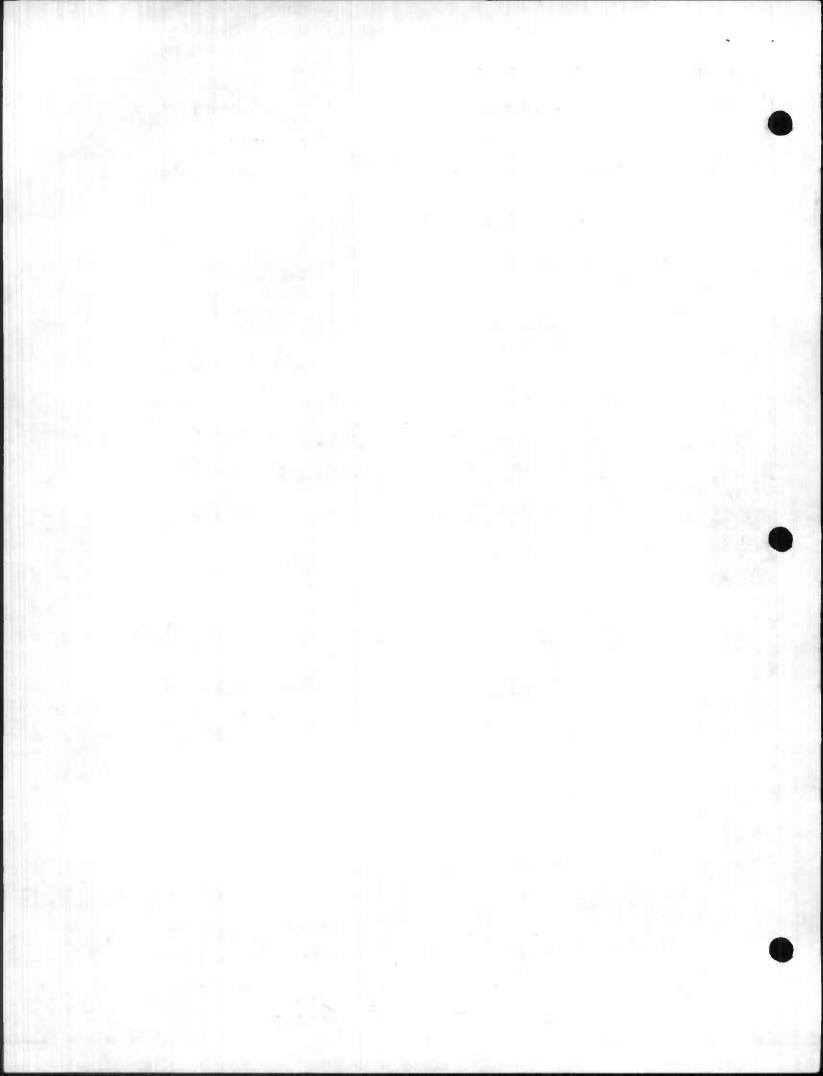
11701

32. Registrer's Signature

DENSUMAN

JIN. 11,

WASK_ Md. 20140

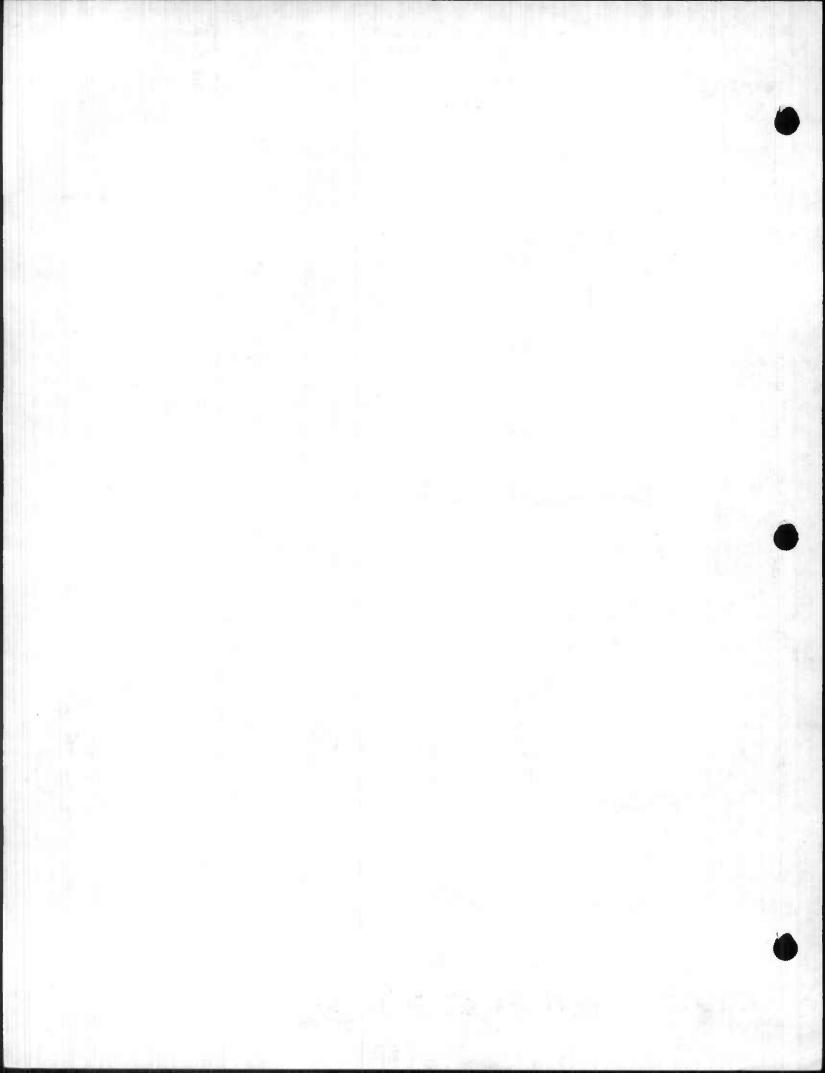


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 0134

	Certificate of Death		Reg. No.	01040						
	Decedent's Name (First, Middle, Last)	2. Date of E	Death Day	3. Time of Death						
ysician Medical	Thomas Lee Gladney	Jan		2000 05:48ai						
aminer	4a Fecility Name (If not institution, give street end number) 4b. City, Tow	m, or Location of De								
	Harbor Hospital Balt	imore	NA.	A						
1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 **TXM 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Deys Hours	4 Hrs. 8. Date of E Min. (Month, I	Birth Dey, Year)	Birthpiace (State or Fore Country)						
Director	213-40-7192 54 16	04-	30-45	MD						
	Usuat Residence of Decedent 10e. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d. inside City Limi						
5	MD NA Baltimore			1 Q Yes 2 1						
or items 23s or 25se-f shoo miner must be notified at Funeral Director	109. Street and Number 10f. Zip Code		10g. Citizen of V	^						
			man oodiniyi							
Funeral		in? (Specify Yea or I	USA No- 14. Raci	e - American Indian,						
Pun /	Armed Forces? If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Rican, etc.) Black, White, atc.							
by	3 Widowed 4 Divorced Yeer or Deles:		Specity	Black						
Per	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	siness/industry						
d other than "nature event, the Medical. Be Completed	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	or working	Depart	tment of						
	12th Grade NA Laborer		Baltin	more City						
Be C	17. Father's Name (First, Middle, Last) 18. Mother	's Name (First, Midd	lle, Meiden Surnam	Θ)						
To	George Gladney Loui	se	Ste	evenson						
-	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number	or Rural Route Num	nber, City or Town,	State, Zip Code) 2120						
	Shirley Hodge 5702 VanDyke Roa	d Baltin	more, Ma	arvland						
	20e. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State MD						
	1 Deliant 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Crownsville Cemete	ry 01-2	1-2000	rownsville						
	21. Signature of Euperal Service Licensee 22. Name and Address of Fecility									
g	WM.C.March FH									
	23a. Part1. Enter the disease, or complications that caused the death. Do monter the mode of dying, such as c			Approximate						
,	shock, or heer failure. List only one ceuse on each line.			Interval Between Onset and Deeth						
	Immediate Cause (Finel	was de	seine							
	Immediate Cause (Finel disease or condition resulting in death) Alters School (Gradus and Due to (or es e consequence of): Due to (or es e consequence of): Sery we described.									
9	bye to (or es e consequence or):									
Examiner	b. Due to for one a consequence of the	Due to (or as a consequence of):								
EXa	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Minsi	Teroien							
edical	that initiated events	00000								
	resulting in deeth) Last									
Z	d									
Cia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.	23b. D	id tobacco use co	ntribute to the cause of dec						
hys			1 Yes 2 No 3 Probably 4							
γ										
Completed by Physician/		24e. W	as an eutopsy orformed?	24b. Were autopsy finding available prior to						
Set			mornieg)	completion of cause of death?						
E		10	Yes 2 () Yo	1□ Yes 2 No						
Ü	25. Was case referred to medical 26 Place	of Death (Check on)								
To Be	exeminer?			er (Specify)						
-	27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred							
te	1 Shetural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 N	lo	281. Location (Street and Number or Rural Route Number,							
fice	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, atreet, factory, office	28f. Location								
er	4 Homicide building, etc. (Specify)	City or	Town, Stete)							
edical Certification:	29a. Certifier (Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and	plece, end due to the	ne cause(s) and me	enner as stated.						
dic	(Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deetlend manner stated.									
Me	29b. Signeture and title of certifier 29c. License number		29d. Date signe	d (Month, Dey, Year)						
) 3064		Janu	ey 18 2000						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1						
		D	001 1	I D. F						
State	Dr. Sabapathi, MD MD. General Professional 31. Date filed (Month, Dey. Year) 32. Registra Signature	Bulluli	IG OZI	v. Eucaw S						
tute	IRM 0 1 2000 \ Ma - \ A A									

DHMH 16 Rev 6/95



VOID CERTIFICATE

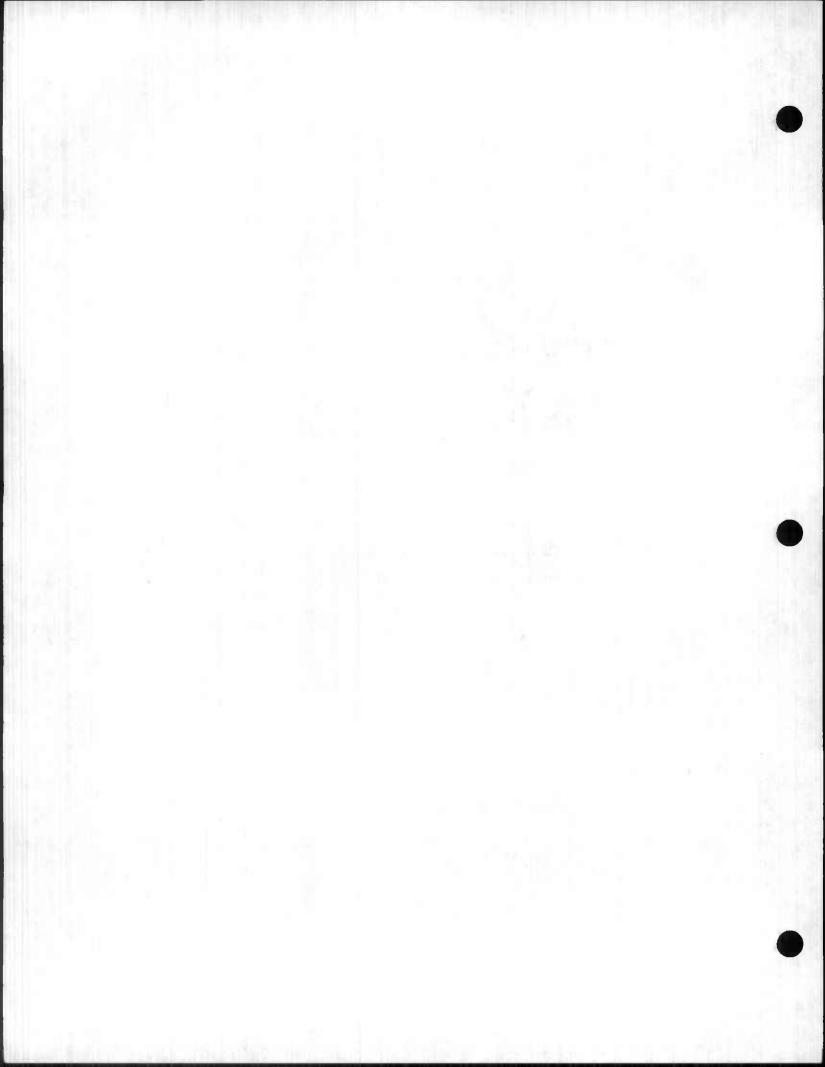
00-01347

SEE

CERTIFICATE M

99 DENTA NUMBEREDIN A 2000 BATEN

> 7/3/2000 En



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM 8 PER FH G779 1/21/2000 AH 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3 Time of Death **Physician** 2000 18 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore. If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland vo/22/09 5. Social Security Number 6. Sex 7. Aga (In yrs, last birthday) 8. Data of Birth (Month, Day. **Funeral** 100M 20 F Months Days Hours Min -1 16 Yrs. Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnsida City Limits 1 ☐ Yas 2 X No Maryland Baltimore Parkville Director 280-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be Harrie 23s 2110 Pitney Road 21234 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or Notif Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Yas 2 No If Yas, Giva Year or Datas: 1 ☐ Never Married 2 ☑ Married b 1 ☐ Yas 2 No Specify: þ White. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Hygiana. be filed within Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12th Grade Clerical Office Maryland 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middla, Last) id Mental marked o Herman B. Holstein Mary Anna Bauerle should DE S 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 and 2 f Health: Nam 27 i Kathy Nunn / Niece 2110 Pitney Road Baltimore, Md. Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata ъ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata ö Important: any injury Greenmount Crematory 1/19/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Schimunek Funeral Home, Inc. 21. Signature of Funaral Sarvice Licenses Mais 3331 Brehms Lane Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete tnterval Between Onsat and Desth **Physician** Immediata Causa (Final disaase or condition rasulting in death) /Medical Examiner Dua to (or as a consequence ot): Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Disease or Injury Box 68760. that initiated events resulting in death) Last use as the P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 | Yee 2 | No 3 | Probably 4 SUnknown signed by þ 90 24b. Were autopsy tindings available prior to complation of causa ot death? page 2 should Be Completed 24a. Wes an autopsy performed? this certificate has 1 ☐ Yas 2 1 No 1 Yas 2/7No after death. Director: After this certifica 25. Was casa refarred to medicat 26. Placa ot Death (Chack only one) Hospitat: t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 20 No Medical Certification: To 27. Manner of Death 28b. Tima ot 28c. Injury at Work? 28d. Describe how injury occurred

of Vital Records, Division

> 0 State

Registrar

the

filled in by

Mospital 24 hours a Funeral

within 2

Ayman F. Akkad, M.D.

rtifiar

5 Pending invastigation

6 Could not be detarmined

1 Natural

2 Accidant

4 Homicide

29b. Signatura and title of

3 ☐ Suicide

29a. Certifier

29c. Licansa number

to the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as steted.

2 Replical Examiner: On the best of axamin unon and or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated.

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Year)

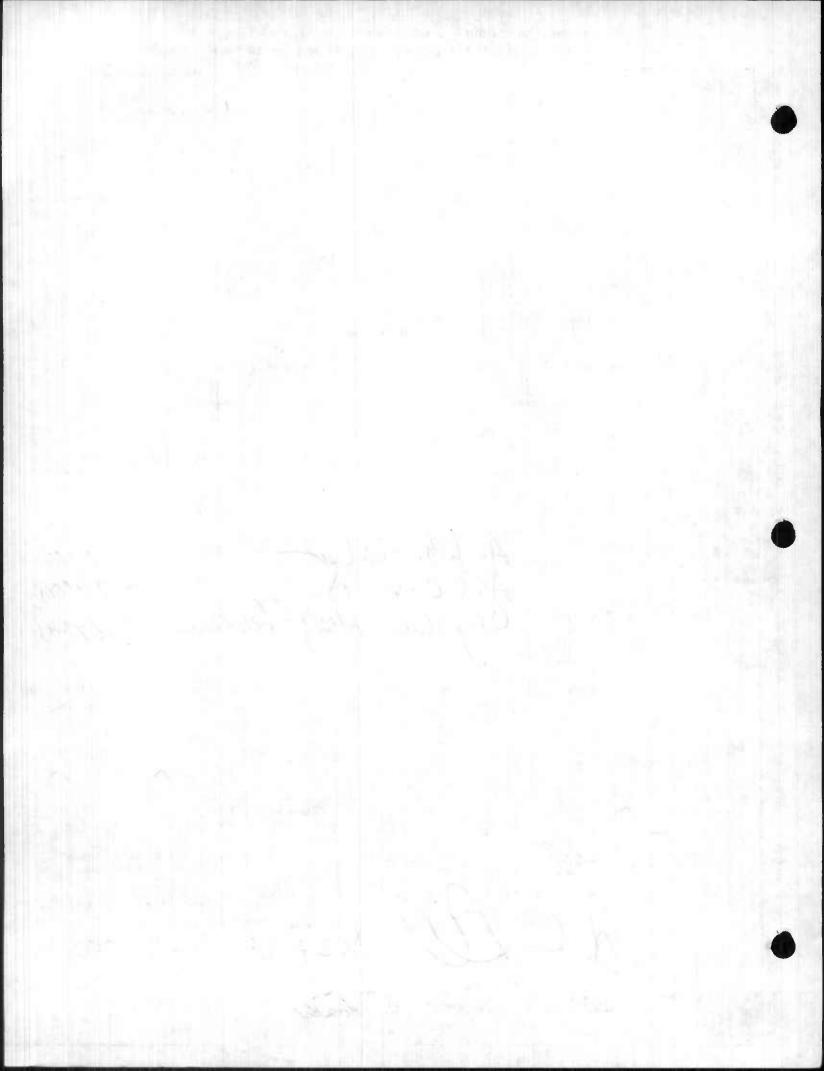
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Nama and eddrass of person who completed cause of death-(Item 23a) (Type, Print)

7600 Osler Drive Towson, Maryland

31. Date filed (Month, Day, Ye 32. Regis ar's Signatura

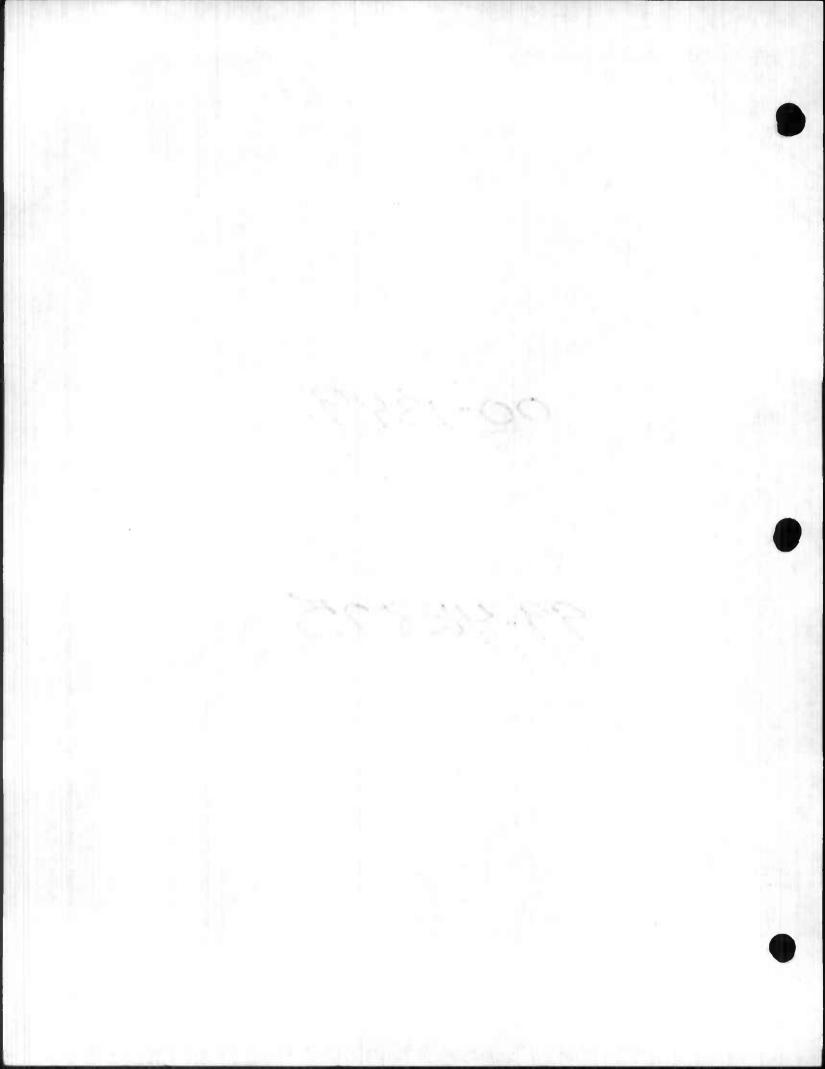
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)



VOID
CERTIFICATE M
OO-1349

SEE

CERTIFICATE MI 99-42875



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18, 2000 Physician 55 JANUARY IRGINIA HAYWOOD /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Maris Mercay Hospice BALTIMORE TA H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 201 Months Days 219-10-0737A Director ME 26,1926 **Usual Residence of Decedent** the Maryland 10b. County 10s. State 10c. City, Town or Location 10d. Inside City Limits MD 1 1 Yes 2 No Director BALTIMORE 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b tresident ST unit 204 21202 U.S. A "natural", or items 23s 250 Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 D No
If Yes, Give
Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examines 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 à 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16s. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FITERVIEWER 1274 HOPKINS Comp RESEARCH NIO Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be RAYMEND . W. KOYSTON MARY SCHMIDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 250 5. President ST. unit 204 BA118. MD 21262 LEONARD HAYWOOD JR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 120 2000 4 ☐ Donation 5 ☐ Other (Specify) FREELAND, 2100 cemetery. MOUNT 22. Name and Address of Fecility HARTLEY MILLER FUNEFAL HOME CHTD. 21. Signature of Funeral Service Licenses tell 7527 HALFORD RD, BA UTO. MD 23a. Part . Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximete Intarvet Between Onset end Deeth **Physician** /Medical Immediata Cause (Finat disease or condition resulting in death) Examiner Estructive Pulmonary Neseaso Examine Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II-Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2000 1 Yas 2 No Division of Vital 26. Place of Death (Check only one) STE //A MARIS AT MERCY 89 25. Was case referred to medical examiner? Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) HOS PICE Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ä 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Attac Attending 1 SNatural 5 Pending investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 8 4 Confiring Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical (Check only To the To To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M

DHMH 16 Rev 6/95

State

Registrar

JAN 2 1 2000

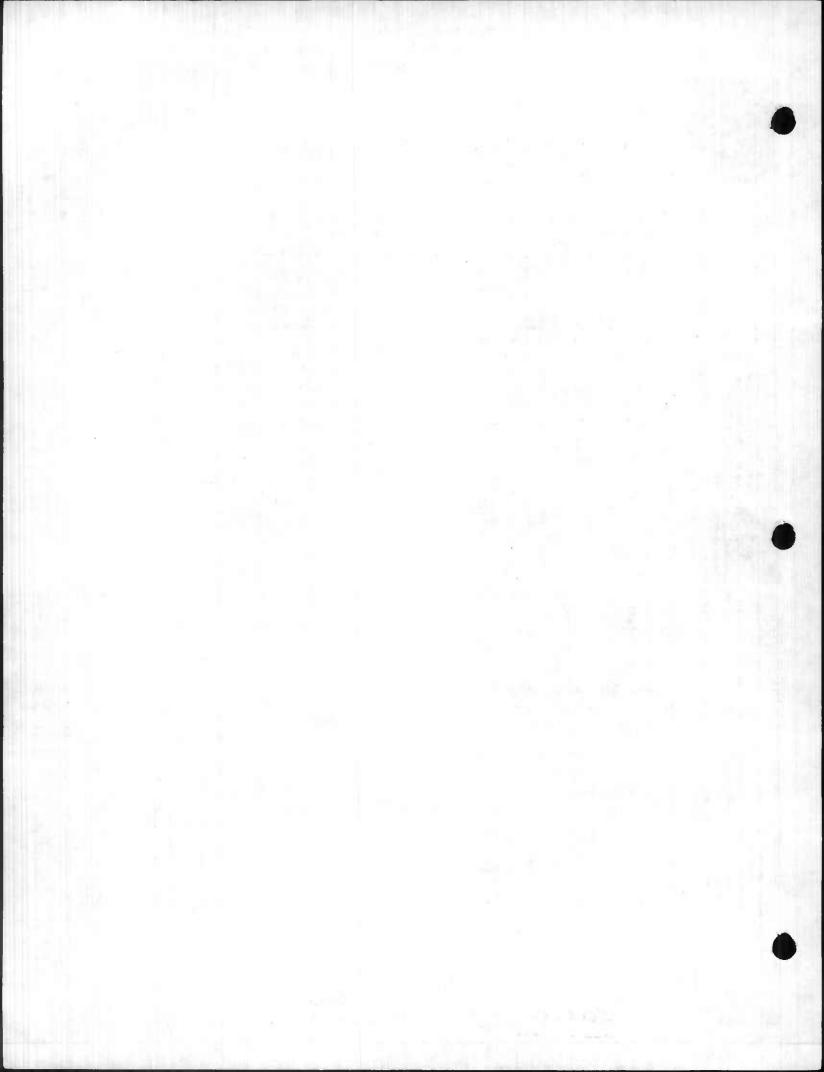
31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hER9

301

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				State	n iviai yiai					and it	nemai m	Reg. No.	J	1351	
	_	. Decedent's Name ((First, Middle, Las	it)									Veer	3. Time of Death	
Physiciar /Medica		Ralph Ellswo	rth Harvey	/										11:50 P.N	
Examine									-			th 4c. County	of Death		
34%				- An	A		K Linder	1 Vaar							
Funeral Director		. Social Security Nun 213–10–3101	2. Date of Death Morth Harvey 3. Time of Death Morth Day 2 2. Date of Death Day 3 2. Date of Death Day 2 2. Date of Death Day 3 2. Date of												
g	-	Jsual Residence of D Oa. State			10c. C	ity, Town or	Location						Year 2000 11:50 P.N. Jounty of Death Baltimore 9. Birthplaca (Steta or Foraign Country) Swanton, Maryland 10d. Inside City Limits 1 Yes 2XJ No en of What Country? d States of America Jeck, White, etc. Jecify: White d of Business/Industry road Transportation Jean City or Town, Stata Monium, Maryland I Home, Inc. Son, Md. 21204 Approximate Interval Between Onsaf and Death Approximate Interval Between Onsaf and Death		
ar death with the Maryland Rems 23a or 23a-f show ner must be notified at	Pottor	Maryland		re Co.		Cockeys	- 7								
th with t		0e. Street and Numb 10200 Greens:									92	-			
3 28 3	by Fur	Marital Status Nevar Married Widowed 4	Armed Forcas? 1 ☐ Yas 2 ② No If Yes, Give									ck, White, etc.			
D-O	Deste	/Specify	lucetion de completed)	cetion 16a. Dec			al Occup	ation during most	t of work	ina	16b. Kind of B	usiness/Ind	lustry		
Maryland 21215-0020 62 should be fluid within 72 hours at th and Mental Hygiene. The marked other than "natural", or traumetic event, the Medical Exami	Completed	Elementary/Second	College (1-4or 5+)								Railroad	d Transportation			
yiand A Wental Hygin riked other effic event, th	o Be	7. Fether's Name (Fi													
E 2 R L					orth)(Wi									Code)	
D - 2 1 5	2	0a. Method of Dispos				Ptace of Dis	position (Ne	me of other plea	00)		Date	20c. Location -	City or To	wn, Stata	
Pages nant of any or o		1 □ Burial 2 □ 0	Cremation 3 L	Entombre	ent Du					dens	01/18/20	000 Timoni	ium, Ma	aryland	
permit. Departments any inja		21. Signature of Funa	aral Service Licen	see Jeffr	ey L. Ga	ir	22. Name ar	nd Addre	ss of Facilit				City or Town, Stata ium, Maryland ome, Inc. , Md. 21204 Approximate Interval Between		
		23a. Paryl. Enter the	dutate, or comp	olication that o	caused the dea	ath. Do not	enter the mod	te of dylr	ng, such as	cardiac	or respiratory	arrest,		Approximate Interval Between	
Physician /Medical		Immediate Cause (Fildisease or condition		872										Onsaf and Death	
Examiner		resulting in death)		8	Due to	(or as a con	sequence of):							932977	
certificate be assected rding physician and use as the burial-transit	ii Examiner														
# 4# #		that initiated events resulting in death) Las		d	Due to (or as a consequenca of):										
for our															
by the		to the Table						ause giv	en in Part I.	•					
been sign											24a. Wa	s an autopsy formed?	ava	allable prior to repletion of causa	
	Eo										125	Yes 2□No	10	Yes 2 No	
certificate	D 2	25. Was case referred	d to medical						26. Place	of Dea	th (Check only	one)			
Physician: The this certificate ral director, pr		axaminer? 1 X Yes 2 ☐ No	0	Hospital: 1	Inpatient 2	XER/Outpa	tient 3 D	DA Oth	ner:				er (Specify	1)	
ding Ph h. After th funeral			Naturat 5 ☐ Pending		28a. Date of Injury (Month, Dey Year)		b. Time of tnjury 28c. tn		- Contract 100						
the ear	e III Ca	2 Accident 3 Suicide 4 Homicide Investigation 1/14/00 5 "00 28e. Placa of Injury - At home, farm, strubuilding, etc. (Specify)					street, factory, offica 28f. L					ell and struck head Location (Street and Number or Rural Routa Number, City or Town, State) 353 Padonia Road			
Hospi 4 hou Funer tely fill	S IRON	29a. Certifier 1 (Check only 2)	Certifying Phy	iner: On the b	asis of examin	owiedge, de	ath occurred	at the tir	ne, date an	d place,	and due to the	ore, MD a cause(s) and m b, date and place,	anner as si	ated.	
To the To the Comple		Signature and titl	te of confilier	and man	ner stated.		29	c. Licens	a number			29d. Date signe	d (Month.	Day, Year)	
F3F8		/ D /	Lord	N	>				C.M.E	- 1				, 2000	
10	3	Name and address	of person who	completed caus	se of death (Ite	m 23a) (Typ	e, Print)								

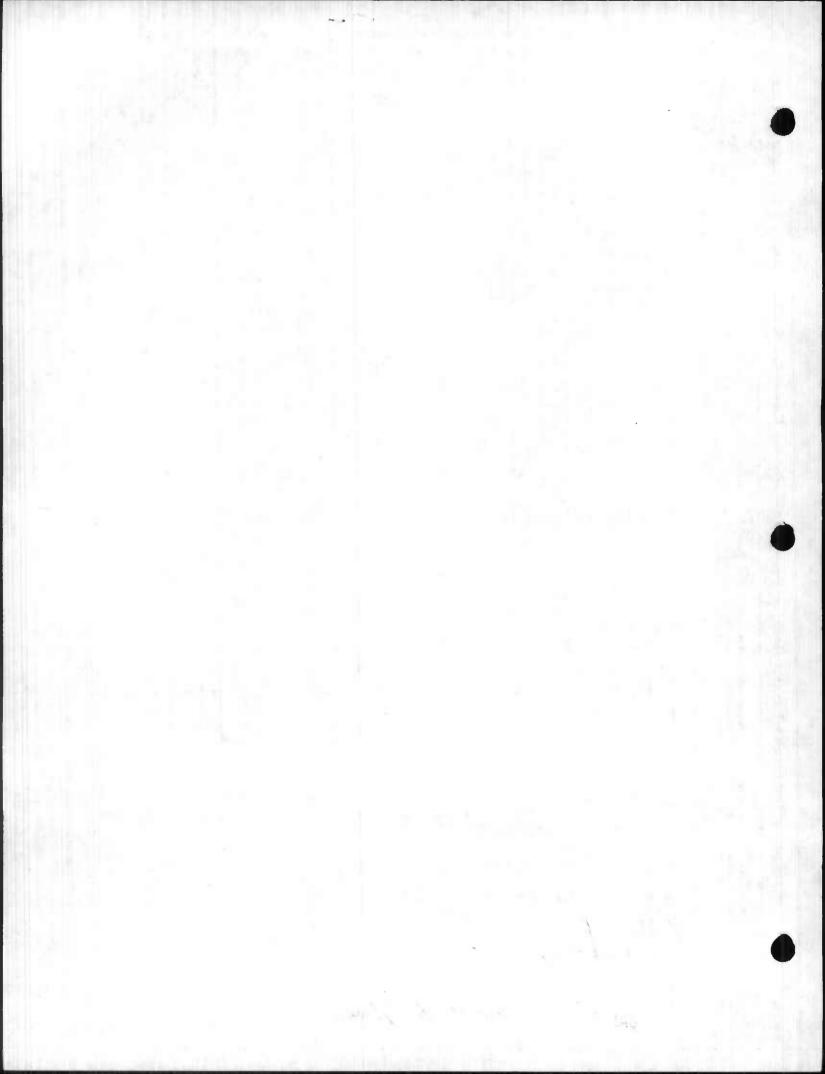
State

J. Laron Locke M.D.
31. Date filed (Month, Dey, Year)

JAN 2 1 2000

32 Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



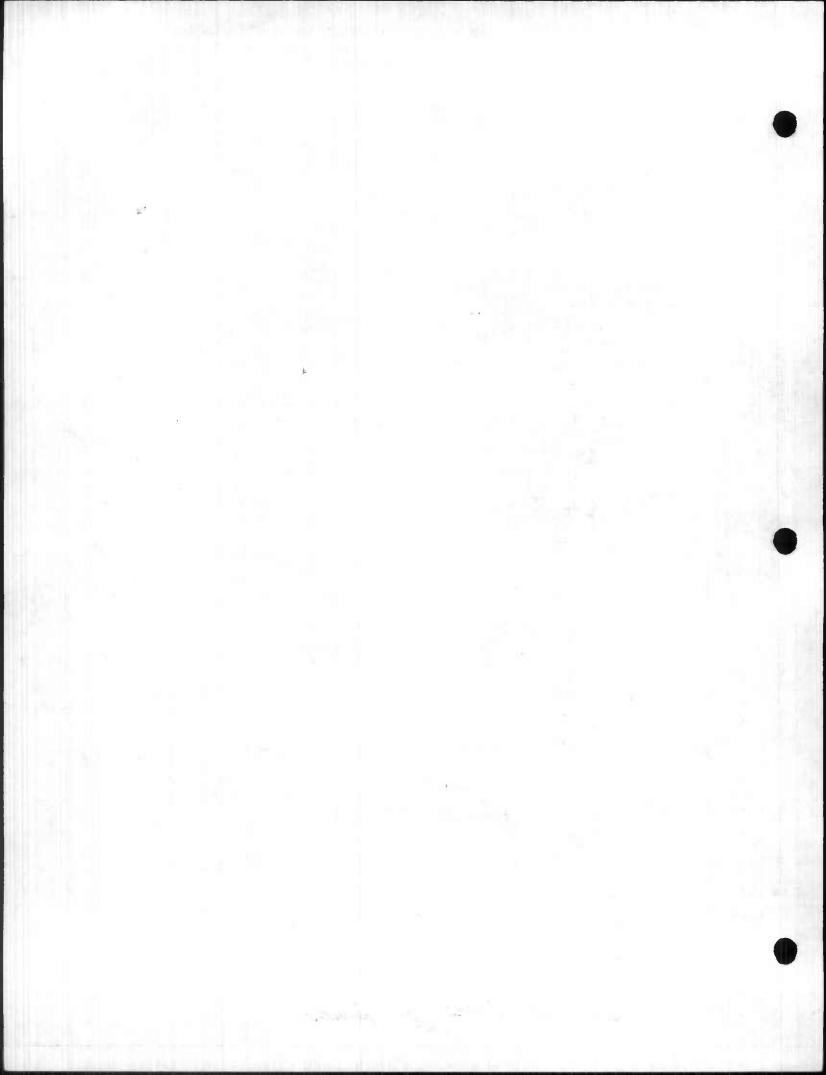
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00	0	1	0	-	-
00	0	1	U	0	6

								eath			Reg. No.			000	
	1. Decedent's Name	(First, Middle, L	est)							2. Date of De Month		Yea		ma of Death	
sician	Merle M.	Howard								Januar	Day	200		:15	
edical miner	4a Facility Neme (If I	not institution, gi	ve street and num	ber)			46	. City, To	wn, or Lo	cation of Deat	h 4c. Co	ounty of De	ath		
	Anne Aru	ndel Med	dical Cer	nter				Annar	oolis	5	Ann	e Aru	nde1		
ral	5. Social Security Nut			7. Age (In yrs. las	t birthday)	If Under 1		If Under 2		8. Dete of Bir (Month, Da				tete or Fore	
or .	215-24-1		1XMM 2□ F	73	Yrs.	Months	Days	Hours	Min.	July 2	y, Year)	6 Ma	Country) rylan	tete or Fore	
be notified at Director	Usuet Residence of E						-			ouly 2	0,132	o Ha	тутап	<u>u</u>	
	10a. State	10b. County		10c. City,	Town or Lo	cation						10	10d. fns	ide City Lim	
ö	MD	Anne A	Arundel	D	eale								10	Yas 2(3)	
Director	10a Street and Num	hor				104 7in (Codo				10a Citiza	Citizen of What Country?			
	10e. Street and Number 10f. Zip Code 20751											USA	20unity r		
Funeral		382 E. Bayfront Road 20751 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu								W 11					
Š	The state of the s		Armed For	ces?	13. V	was Decede f Yes, specif	fy Cuban	, Mexican	, Puerto	Rican, etc.)	14.	Black, Wh	nerican Indi nite, etc.	an,	
Y F	1 Never Married		1XX es If Yes, Give		1	1□Yes 2	X No	Specify:			Specify: White				
D	3.K.I Widowed 4	3 ☑ Widowed 4 □ Divorced Year or Dates: KO			an										
ote	(Specif	15. Decedent's Education (Specify only highest grade completed)				lent's Usual kind of work	Occupat k done du	ion ining most	of worki	na	16b. Kind	of Busines	s/Industry		
Completed	Elemantary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)														
00	2				Equip	ment (Oper	ator/	Farm	ner	Anne	Arund	el Co	. Gov	
Be	17. Father's Name (F	First, Middle, Las	1)					18. Mothar's Name (First, Middle, M			, Maiden Su	Maiden Sumame)			
OB	James Vi	rgil Hov	vard					Rosi	Le Ma	Mae Armiger					
-	19a. tntormant's Nan	me/Ralationship	(Type, Print)		19b. Maitin	ng Addrass	(Street a	nd Numbe	or or Rura	Rural Route Number, City or Town, State, Zip Code)					
	Merle W.				382	E. Bay	yfro	nt Ro	oad.	Deale,	MD 2	0751			
	20a. Method of Dispo	osition		20b. Plac	e of Dispos	sition (Name	e of	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	Date			or Town, Sta	ite	
	1 ☐ Burial 2🛣	Cremation 3 [Removal from S	tate	_	natory or oth)	1 9	1/17					
	4 Donation 5			Me L		emato				2000	Baltimore, MD				
	21. Signature of Fund	eral Service Lice	nsee	1.		Name and				Home, F	Δ				
	1 1 hic	heles	(J. *	11/10			_			Annapo		MD 21	401		
	23a. Part1. Enter the	e disease, or cor	nplications that ce	used the death.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Appro	ximate al Between	
al Examir	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or In that Initiated events	ditions, mediate lying njury		Due to (or a	Por	eum	one	2,					1/2	wee	
Medic	resulting in death) La	ast	Z C	Due to (or as	a consequ		01	7,5					1 11.	(and	
for use a	1		d. de s	chein	5.		Sle	(,)					1/2		
in C			d. 4-3										1/2		
ysicial	Part It. Other eigniftc	ant conditions	d							23b. Dld	tobacco ue	• contribu	to to the ca		
Physician	\wedge	eant conditions									tobacco ue Yea 2		ite to the ca		
Ď	\wedge		-2	ath but not resulting	ng in the ur	nderlying ca				10	Yes 20	No 3□	Probably	45 Linkn	
Ď,	\wedge		-2	ath but not resulting	ng in the ur	nderlying ca	use give			1 🗆		No 3□	Probably D. Were autoevailable	opsy finding	
ğ	\wedge		-2		ng in the ur	nderlying ca	use give	n in Part I.		1 🗆	Yea 2	No 3□	Probably D. Were autoevailable	4 Unkr	
Ď	\wedge		-2	ath but not resulting	ng in the ur	nderlying ca	use give	n in Part I.		1 🗆	Yes 2	No 3 -	Probably D. Were autovailable completion	opsy finding prior to n of cause	
Completed by	De Rig	manti	-2	ath but not resulting	ng in the ur	nderlying ca	use give	n in Part I.	Mon	1 🗆 24a. Was perfe	an autopsyomed?	No 3 -	Probably D. Were autoevailable completion of deeth?	opsy finding prior to n of cause	
Be Completed by	De Rig	that H	P 4	ath but not resulting	ng in the ur	nderlying cal	Q3	on in Part I.	7704	1 24a. Was perfo	Yes 2 (Culture)	No 3	Probably D. Were autorial evailable completion of deeth? 1 Yes	opsy finding prior to n of cause	
To Be Completed by	De Rig	that H	Hospital: 1 Dur	ath but not resulting	ng in the ur	nderlying car	A Other	26. Place	of Death	1 □	Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes	No 3 24t	Probably D. Were autorial evailable completion of deeth? 1 Yes	opsy finding prior to n of cause	
To Be Completed by	25. Wes case raferre examiner? 1 Yes 201N 27. Manner of Death	ht H	Hospital: 1 DIr	ath but not resulting	ng in the ur	nderlying car	Other	26. Place	7/04 of Death	24a. Was performe 5 🗆 Resident Residen	Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes	No 3 24t	Probably D. Were autorial evailable completion of deeth? 1 Yes	opsy finding prior to n of cause	
To Be Completed by	25. Wes case raferre examiner? 1 Yes 2010.	that the did not be di	Hospital: 101r	patient 2 EF	No of the unit of	nderlying call	Other Control Contr	26. Place	7/04 of Death	24a. Was perfu	Yes 2 Yes 2 Yes 2 Yes 2 Yes how injury c	No 3 24b	Probably D. Were autovaliable completion of deeth? 1 Yes	opsy finding prior to n of cause 2 No	
To Be Completed by	25. Wes case raferre examiner? 1 Yes 20 N 27. Manner of Death 1 Natural 2 Accident	ht H	Hospital: 1 28a. Dete of (Month)	ath but not resulting	No of the unit of	nderlying call	Other Control Contr	26. Place	7/04 of Death	24a. Was performent of the control o	Yes 2 Yes 2 Yes 2 Yes 2 Yes how injury c	No 3 24b	Probably D. Were autovaliable completion of deeth? 1 Yes	opsy finding prior to n of cause 2 No	
Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 201 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida	ht H	Hospital: 1 Dar 28a. Place o buildin	patient 2 EF	VOutpatien 8b. Time of Injury	nderlying car at 72/ at 3 DOA 28 M eet, factory,	A Other	26. Place 26. Place A Numati	of Death	24a. Was performe 5 Resized Describe	Yes 2 Street and N	No 3 24t	Probably D. Were authentiable completion of deeth? 1 Yes Proceedings of the second	opsy finding prior to n of cause 2 No	
Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 2 No. 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 HomicIda	by the second of	Hospital: 1 DIT 28a. Dete of (Mont) 28a. Place of building building 1 buil	patient 2 EF I Injury Delinjury - At home g, etc. (Specify) post of my knowle	VOutpatien Bb. Time of Injury	ot 3 DOA 28 M eet, factory,	OSC Injury Work's office	26. Place The second at 7 res 2 1 ft.	of Death	24a. Was performed to the control of	Yes 250 one) dence 6 [how injury of wm, State) causa(s) an	No 3 24th	Probably D. Were automorphism of deeth? 1 Yes Paral Route es stated.	opsy finding prior to n of cause 2 No	
edical Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 20 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only one)	in en 72 hd H de to medicat io 5 Pending investigation 6 Could not I determined Could not I determined Medical Example Medi	Hospital: 1 28a. Dete of (Month) 28a. Place of buildin	patient 2 EF I Injury Delinjury - At home g, etc. (Specify) post of my knowle	VOutpatien Bb. Time of Injury	nderlying call at 3 DOA 28 M eet, factory,	Other Sc. Injury Work 1 Y office	26. Place 26. Place 4 Num 81 7 9 9 0 0 0 0 0 0 0 0 0 0 0	of Death	24a. Was performed to the control of	Yes 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 3 24t	Probably D. Were automorphism of deeth? 1 Yes Decity) Rural Route es stated. us to the ca	opsy finding prior to n of cause 2 No	
Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 2 No. 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 HomicIda	in en 72 hd H de to medicat io 5 Pending investigation 6 Could not I determined Could not I determined Medical Example Medi	Hospital: 1 DIT 28a. Dete of (Mont) 28a. Place of building building 1 buil	patient 2 EF I Injury Delinjury - At home g, etc. (Specify) post of my knowle	VOutpatien Bb. Time of Injury	nderlying call at 3 DOA 28 M eet, factory, a occurred all restigation, i	Other Sc. Injury Work 1 Y office	26. Place 26. Place 4 Num at 7 es 2 h	of Death rsing Hor No	24a. Was performed to the control of	Yes 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 3 24t	Probably D. Were automorphism of deeth? 1 Yes Paral Route es stated.	opsy finding prior to n of cause 2 No	
edical Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 20 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only one)	in en 72 hd H de to medicat io 5 Pending investigation 6 Could not I determined Could not I determined Medical Example Medi	Hospital: 1 DIT 28a. Dete of (Mont) 28a. Place of building building 1 buil	patient 2 EF I Injury , Day Year) of Injury - At home g, etc. (Specify) pest of my knowle sis of examination or stated.	VOutpatien Bb. Time of Injury	nderlying call at 3 DOA 28 M eet, factory, a occurred all restigation, i	Other Sc. Injury Work 1 Y office	26. Place 26. Place 4 Num at 7 es 2 h	of Death rsing Hor No	24a. Was performed a control of the	Yes 2 One) Idence 6 Chow injury commod? Street and Nown, State) Causa(s) and data and pi	No 3 24th No 2	Probably D. Were automorphism of deeth? 1 Yes Paral Route es stated. ua to the ca	oppy finding prior to n of cause 2 No Number, on Number	
edical Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 20 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only one)	d to medicat do 5 Pending investigation 6 Could not I determined the Certifying Promote Medical Examination	Hospital: 28a. Dete of (Month) 28a. Place of building and manner. Mysician: To the bar and manner.	patient 2 EF Injury, Day Year) of Injury - At home g, etc. (Specify) pest of my knowles is of examination or stated.	VOutpatien b. Time of Injury e, farm, stru	of 3 DOA A Book factory, a occurred at restigation, i	Other Sc. Injury Work's 1 Y office	26. Place 26. Place 4 Num at 7. es 2 1	of Death rising Hor No	24a. Was performed a control of the	Yes 2 One) Idence 6 Chow injury commod? Street and Nown, State) Causa(s) and data and pi	No 3 24th No 2	Probably D. Were automorphism of deeth? 1 Yes Paral Route es stated. ua to the ca	oppy finding prior to n of cause 2 No Number, on Number	
edical Certification: To Be Completed by	25. Wes case raferre examiner? 1 Yes 20 N. 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 29a. Certifier (Check only one) 29b. Signature end tit	d to medicat do 5 Pending investigation 6 Could not I determined the Certifying Promote Medical Examination	Hospital: 28a. Dete of (Month) 28a. Place of buildin hysician: To the bar and mann completed cause	patient 2 EF Injury Delinjury - At home g, etc. (Specify) Dest of my knowle sis of examination er stated.	VOutpatien b. Time of Injury e, farm, stru	nderlying call at 3 DOA 28 M eet, factory, a occurred all restigation, i	Other Sc. Injury Work's 1 Y office	26. Place 26. Place 4 Num at 7. es 2 1	of Death rising Hor No	24a. Was performed a control of the	Yes 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 3 24th No 2	Probably D. Were automorphism of deeth? 1 Yes Paral Route es stated. ua to the ca	oppy finding prior to n of cause 2 No Number, on Number	

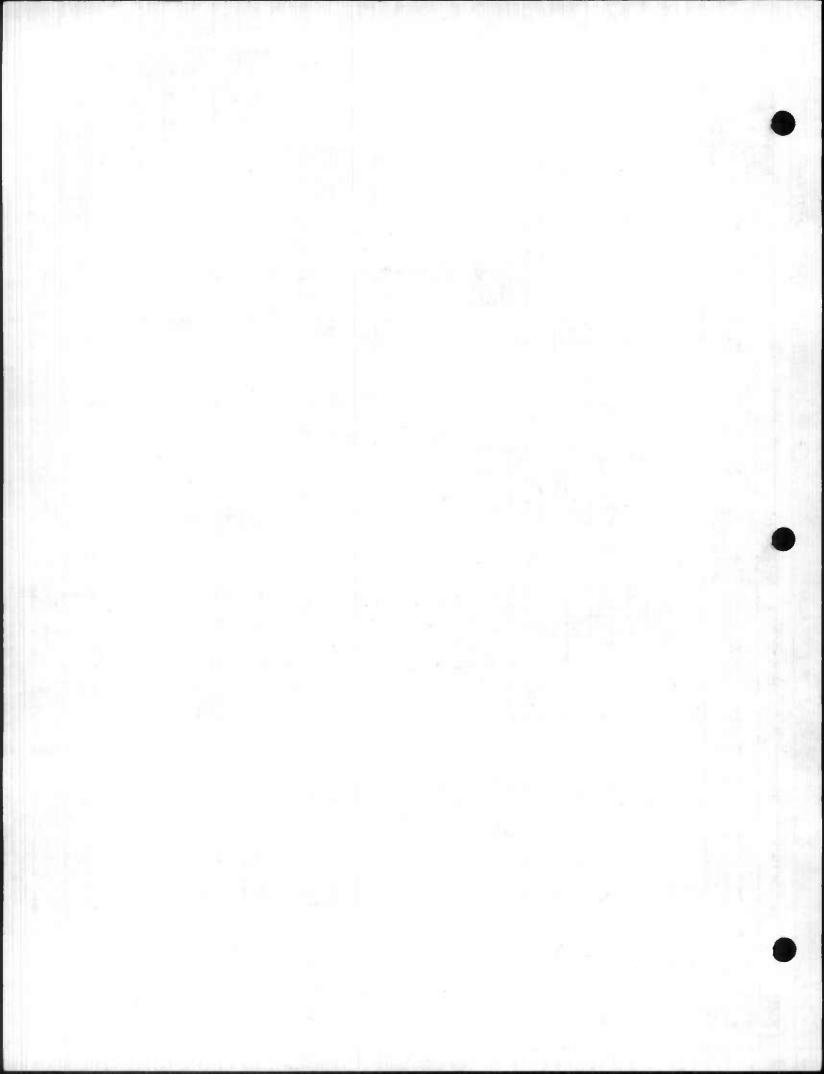
DHMH 16 Rev 6/95



	Decedent's Name (First, Mid-	dle, Last)						2. Date of D	eath	1 :	3. Time of Death	
sician	BARBARA JEAN HOLMES							Januar Tanuar	Day	Year	1640	
edical 4	Facility Nama (If not instituti					4b. Cit	y, Town, or L	ocation of Dea	7 7 1 1 1 1			
101	FALLSTON GEN	ERAL HOSP	ITAL				FALLST	ON	н	ARFORD		
5.	Social Security Number	6. Sex	?. Age (In yrs.	. last birthday)	If Under 1 Y		nder 24 Hrs. urs Min.	8. Data of Bi (Month, D	rth	9. Birthplac	e (State or Foreig	
	250-64-1520	1□ M 2☑★	6	51 Yrs.	MOINIS De	ays (10	uis wiii.	OCT 30			CAROLINA	
_	sual Residence of Decedent Oa. State 10b. Count	N .	10c C	ity, Town or Lo	cation					104	Inside City Limit	
				EDGEW						1.00.	1 ☐ Yes 2 ☑ M	
-	IARYLAND H.	ARFORD		da			10a Citizen a	10g. Citizen of What Country?				
	644 LONGWOOD	COLLDE			10f. Zip Coo	21040			U.S.			
1	1. Meritel Status		coedent Ever in U,S. 13. Was Decedent of H Forces? 13. Was Decedent of H				ic Origin? (Sp	ecify Yes or N		ace - American	Indian,	
·	1 Never Merried 2 Ma	Armed F urried 1 ☐ Yes	1 ☐ Yes 21K0No					Rican, etc.)		lack, White, etc.		
	3€Vidowed 4 □ Divorce		If Yes, Give 1 Vear or Detes:			No Spe	ecify:		Spec	BLACK		
		ent's Education				ccupation	most of word	ina	16b. Kind of	Business/Indus	try	
(Specify only highest grade completed) (Give kind of work done during to life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+)						most or work	9					
_	12th	2yrs	2yrs OPE			ERATING ROOM TEC			HEA	2		
17	7. Father's Name (First, Middle	e, Last)				18. N	Aother's Nam	e (First, Middle	, Maiden Sum	ame)		
L	JOSEPH JONES							ZZIE ADAMS				
1	9a. Informent's Name/Relation	nship (Type, Print)		-			t and Number or Rural Route Number, City or Town, State, Zip Code)					
L	Barbara P. Ha	rvin/Daugl					nue, B		e, Mary			
20	Da. Method of Disposition 15 Burial 2 □ Cremation	3 Removal from		Place of Dispo- cemetery, crem	natory or other	place)	i .	Deta	20c. Locatio	n - City or Town	, State	
-	4 Donation 5 DOther ((Specify)	G.F.	ARRISON	FOREST	<u> </u>	ļ	-25-00	OWINGS	MILLS,	MARYLAN	
2	Signature of Funeral Service	s Licenses			Name and A			MMIINT TOS	T PIIMPD:	AT HOME	DA	
	Dustares	4. Oron	_		1111AM				FUNERA	AL HOME	PA	
O I II	iequentially list conditions, any, leading to immediate ause. Enter Underlying euse (Disease of Injury let initieted events soulting in death) Last	6. Ch	Due to (c	deperor as a consequence or as a consequence	pail	Ty	ge I	I de	abetes	milli	tus/yea	
Pi		a Clarke myocardial unfa						clim		de	Ryo	
L				1			0	1				
Pa	art II. Other algnificant condit	iona contributing to	death but not resulting In the underlying cause given in Part					23b. Did tobacco use contribute to the cause				
_	hyper	eusion						1 Yaa 2 No 3			oly 4 Unkno	
	0"							24a. We	s an autopsy	24b. Were	autopsy findings	
								pen	ormed?	comp	able prior to detion of cause ath?	
								10	Yes 2 No	1 9 10	es 2□No	
2	5. Wes case referred to medic	al				26 (Place of Desi	th (Check only				
	examiner?	Hospital	Inpatient 2	ER/Outpatien	3 DOA	Other			idence 6 🗆 C	Other (Specify)		
27	7. Menner of Death	28a. Dete	of Injury	28b. Tima of		injury at Work?			how injury occ			
							2 🗆 No	No 28f. Location (Street and Number or Rural Route City or Town, State)			loute Number,	
21		ing Physician: To the i Examiner: On the i										
	9b. Signature and title of certifi	ier /	0		29c. Lic	cense num	ber		and Date sig	ned (Month, De	y, Year)	
	DO115	Un 1	/	0	MT	5	1875	9	Lorens	10	7000	
1			1444 //	1/ 1	10 //		0 / /					
30). Name and address of person	n wto completed car	ise of death (item	m 23a) (Type I	Print)	AI	REPA	-50	SUN	MA	7	
30). Name and address of person	n who completed cau	use of death (iter	m 23a) (Type, I	Print) Fal.	AL	BERT	5.0	54N	MD.	X	

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year 3 DONNA JAN 19 00 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 215-42-1768 10 M 20 F 54 Yrs. MD Feb. 9, 1944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Raspeberg 1 ☐ Yas 🎾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4322 Woodlea Ave. USA 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. Whita, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Nevar Married 2 Merried 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Glen McDaniel Mary Mocere 19a. Informant's Name/Relationship (Type, Print) Michael Hart / son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4322 Woodlea Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete Metro Crematory or other place) 1 ☐ Burial 2 🏋 Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-22-00 Catonsville, MD 22. Name and Address of Facility
Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Ligense 1211 Chesaco Ave. Rosedale, MD 23a. Pert 1. Enter the disease, or complications that caused had shock, or haart feilure. List only one cause on each limit ith. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximete Intervel Between Onset and Deeth Immediete Cause (Final disaase or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vonknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yaş 27. Manufer of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ∏Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

mast be n

Nerne 23a

8

permit. Pages I and 2 should be filed within 72 ! Department of Health and Mental Hygiens. Important! If item 27 is merked other than "nah any Injury or other thaumatic event, the Medical

Director

Funeral

þ

Completed

Be

the Maryland

hours after

altimore, Maryland 21215-0020

Examiner the buriel-transit and US0 23 been signed by should be detac page 2 certificate funeral director, After this

or Attending Physician: The law requires that the deeth certificate be executed P.O. Box 68760, Division of Vital Records, after death. filled in by the Medical

Physician/Medical Completed by Be Certification: To

To the Hospital of the Hospital of the Funeral Discount etely filled in

State Registrar

29a. Certifier 1d Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 29b. Signature and

6 Could not be determined

3 Suicida

31. Date filed (Mor

4 Homicide

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

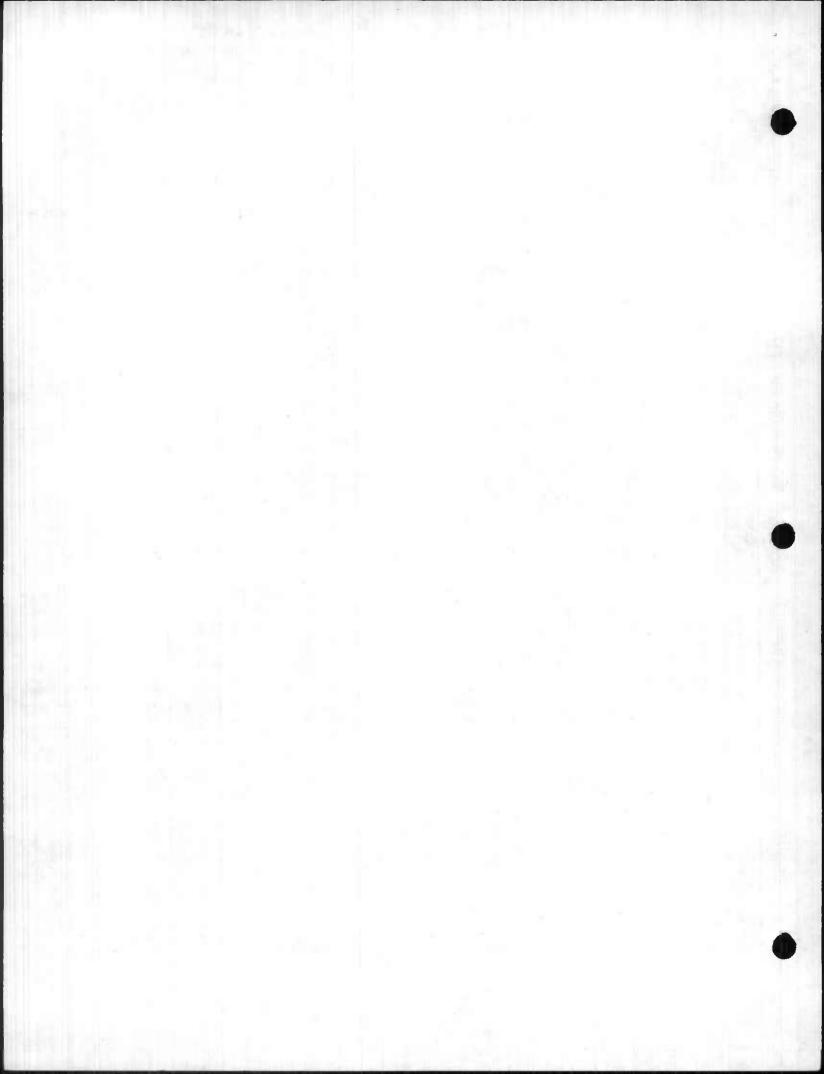
29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ath (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Yeer **Physician** Stanley January
4b. City, Town, or Location of Death Horsley 6 appm 19,12000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltomore Franklin Square Hospital Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Conter | If Under 1 Year If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 □ F 220-07-0209 86 Director VA Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. MD Baltimore Rosedale 1 Yas 2 No Director "natural", or liams 23s or 28s-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1251 Neighbors Ave. 21237 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 27 No 1 Yes ¾ No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Sales Person Green Spring Dairy 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental Cephas Horsley Eva B. Horsley 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print)
Margaret M. Horsley / tant: If Ihem 27 is wife 1251 Neighbors Ave. Rosedale. MD 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition cemetery, cremetory or other place)
Holly Hill 1 X Burial 2 Cremetion 3 Removel from Stete 1-24-00 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licenset 22. Name and Address of Facility Cvach/Rosedale Funeral Home Chesaco Ave. Rosedale, MD Mike 23e. Pert1. Enter the disease, or complications that caused the death shock, or heer fallure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner ician and bunal-transit The law requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the bunal Box 68760, Physician/Medicai Due to (or as a consequence of): signed by the atte 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24e. Was en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funezal Director: After this certifica completely fiffed in by the funeral director. 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner steted. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie CM, alli

State Registrar

31. Date filed (Month, Day, Year) JAN 21 2000 **DHMH 16 Rev 6/95**

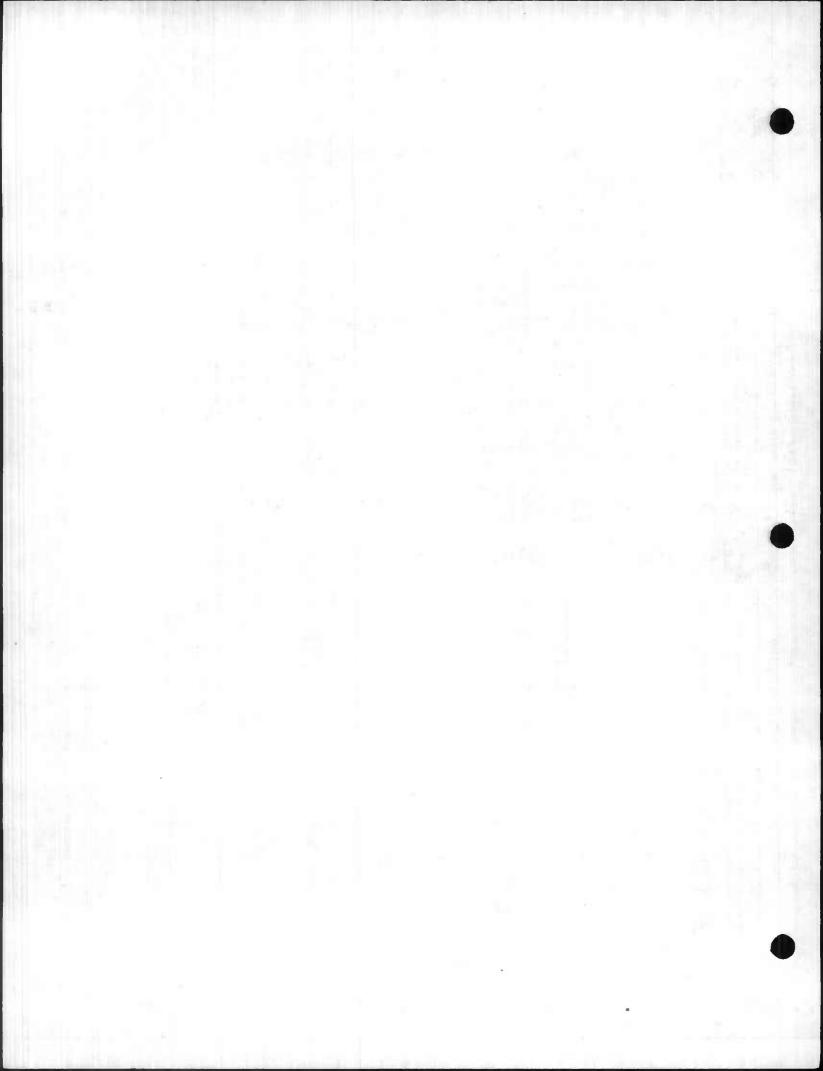
Dr Stuart R. Willes

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

9000 Franklin Square Drive, Baltimore Maryland 21237 32. Registrar's Signeture

1236663

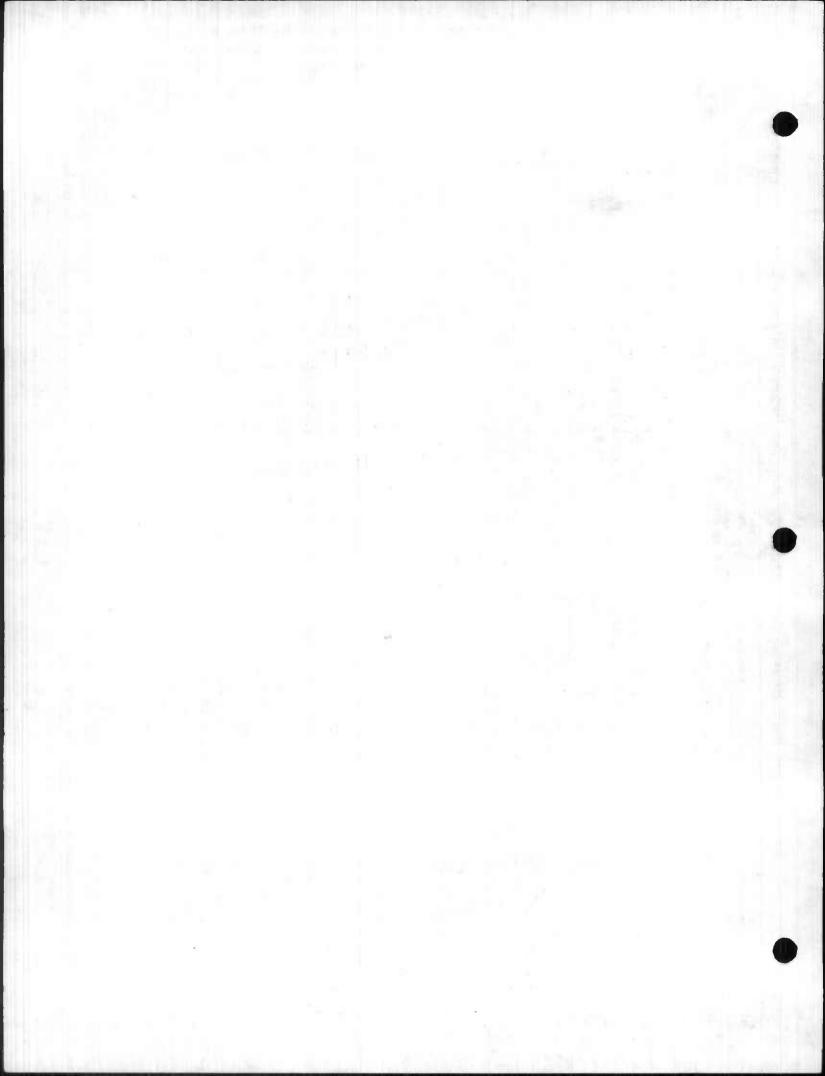
January 19,2000



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** DENISE **JAMES** /Medical JANUARY 14 2000 24:08 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE
If Under 24 Hrs. Hours Min. CITY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Fereign 8. Dete of Birth (Month, Day, Year) **Funeral** Months 1 M 2 A Days 212-80-123 Usuel Residence of Deceder -80-123 Yrs Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itama 23a or 28a-f ahow 1 DYes 2 □ No Director timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21212 5.4 14. Race 100d Street. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiena.

Artif item 27 is marked other then "natural", or he way or other traumate event, its lies of the market of the lies of the 1 Never Married 2 Merried Black 21215-0020 1 □ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busi ltimore Elementery/Secondary (0-12) College (1-4or 5+) ateleri Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 Liveberger Iame 5 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 2 0 James mothe 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Department | Important: If 22-00 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensus 22. Name end Address of Fecility Mille +Services 1639 23a. Part Employe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, should be perfectly fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) 01 DAY diseese or condition resulting in deeth) e. DIFFUSE CEREBAL EDEMA Examiner Due to (or as a consequence of): Physician/Medical Examiner sloian and bunal-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760, Due to (or es a consequence of): 93 980 P.O. signed by the a Part II. Other algorithmat conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4) Unknown Records. ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s VO Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2♥ No Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division or Attending 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No death. 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture and affle of certifier 29c. License number RES-000 **JANUARY 14 2000** 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) REIMSCHISEL MD 600 NORTH WOLFE BALTIMORE, MD 21287 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State oaks JAN21 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHNSON HERMAN 2000 0650 AM JAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 51LCHRIST BALTIMORE CENTER If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1.8 M 2□ F 141-30-3664 Yrs. Director NEWJERSE Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE CIT Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? 8 8 BRANTLEY KOAD 45A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ₺ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementery/Secondery (0-12) College (1-4or 5+) SALESMAN 2 THGRADE 4 YRS, A LCOHOL BEVERAGE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Mental JOHNSON SR. HERMAN JUANITA 1 UCKER Pages 1 and 2 should 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town JUANITA TUCKER JOHNSON (MOTHER) reportant: If frem 27 altimore, 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GROFTON BAPT, CHURCH (EME'D)-22-00 MIDDLESEX, VIRGINIA 22. Name end Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 21. Signeture of Fureral Service Licensee 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate **Physician** geal CANCEY Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 | Nursing Home 5 | Residence 6 (Other (Specify) | 10 Spice Certification: To 1 Yes 2 No this funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending 1 Yes 2 No death. 2 Accident investigation after death Director: 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide 5 within 24 hours a Hospital Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. tely (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stelled. \$ 29b. Signature and otle of certifier 29d. Date signed (Month, Day, Year) 29c. License number 192901 JANUARY 18,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley GBMC CTOI N . Charles St, Towson, mp 21204

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

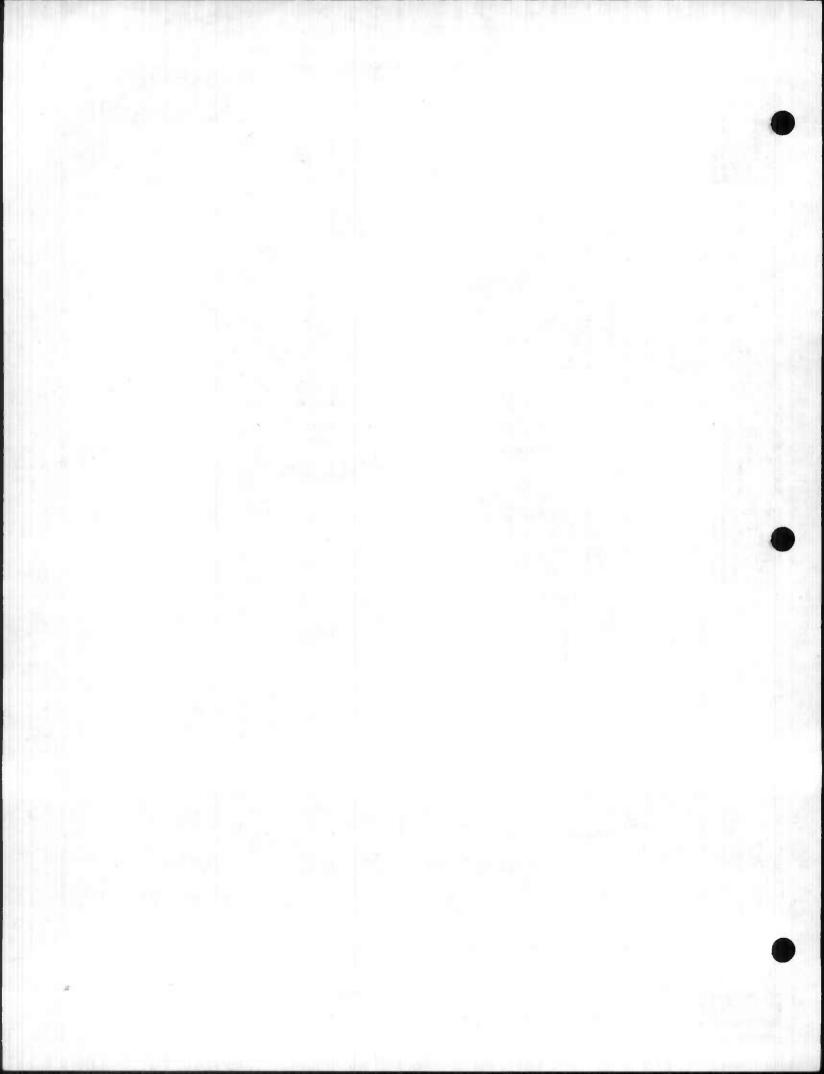
anufry 18,2000

32. Registrer's Signeture

Denev

2000 ▶

JAN 21



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month **Physician** January 20, 2000 5:35AM Emma Cheatham Jones /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chapel Hill Nursing Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 10 M 20 F Yrs. 66 Feb. 5, 229-68-9489 Director Usual Rasidence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural" ---eny injury or other traumatic even. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Funeral Director Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Coda 271 Hammershire Rd. 21136 USA 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 💢 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Datas: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 10 Certified Nursing Assistant Medical 17. Fathar'a Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Walter Riley Cheatham Elizabeth Elliott 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Daughter Rt. 1, Box 94, Pamplin, VA 23958 Marva Thorton 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata St. Luke Cemetery 1/23/00 Brookmeal, VA 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatureyol Funeral Service Licensee 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD Lun cins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Physician Syndoon Hepato Pulmoning Imprédiate Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseese or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) and Box 68760. Physician/Medicai the Dua to (or as a consequanca of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 10 3 Probably 4 Unknown by Division of Vital Records, 24b. Wara autopsy findings available prior to complation of cause of daath? page 2 should 24a. Was an autopsy performad? Completed 1 Yaa 2 TNo 1 ☐ Yas 2 ☐ No Physicien: luneral director. Medical Certification: To Be 25. Was case refarred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No this 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 27. Mannar of Death 28d. Dascribe how injury occurred After t or Attending 5 Pending investigation 1 [9Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 □ Yas 2 □ No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Ptaca of Injury - At home, farm, straat, factory, offica building, atc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 94 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) > Roll J. Mor MO 032882 2000

State Registrar

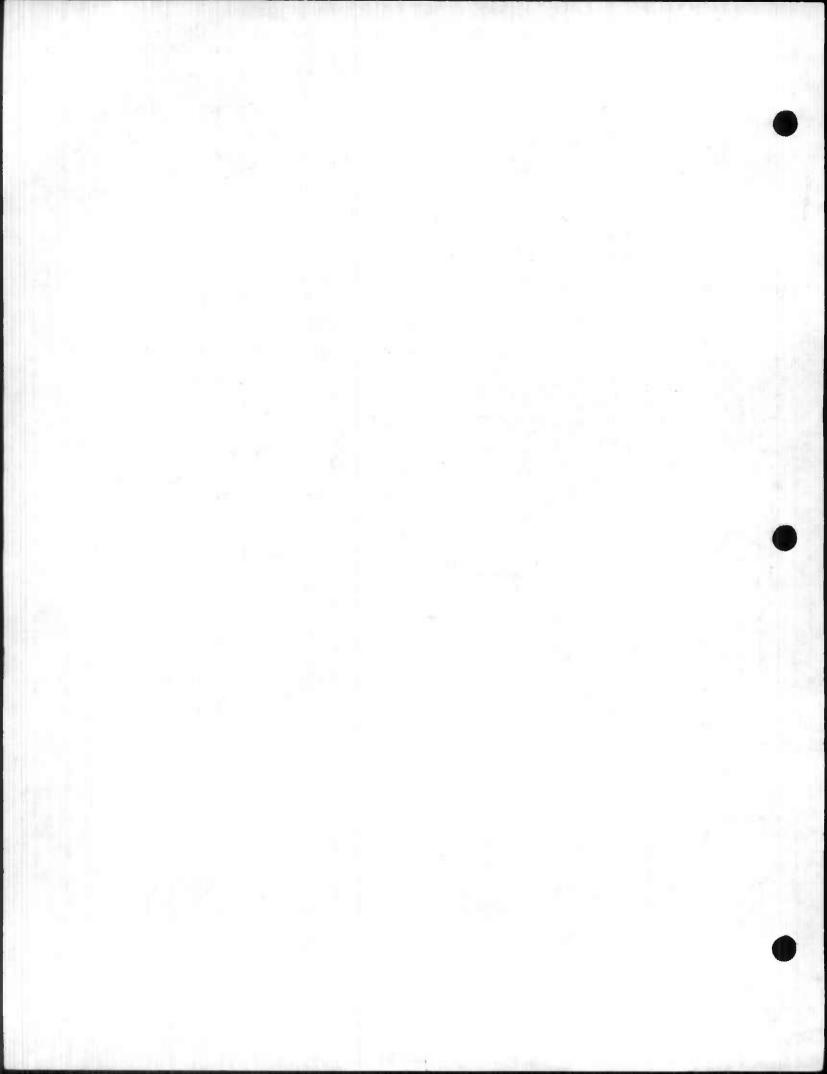
DHMH 16 Rev 6/95

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Completed Causa of death (Itam 23a) (Type, Print)
| Complete Causa of death (Itam 23a)

poorted

Center Dr. Restante



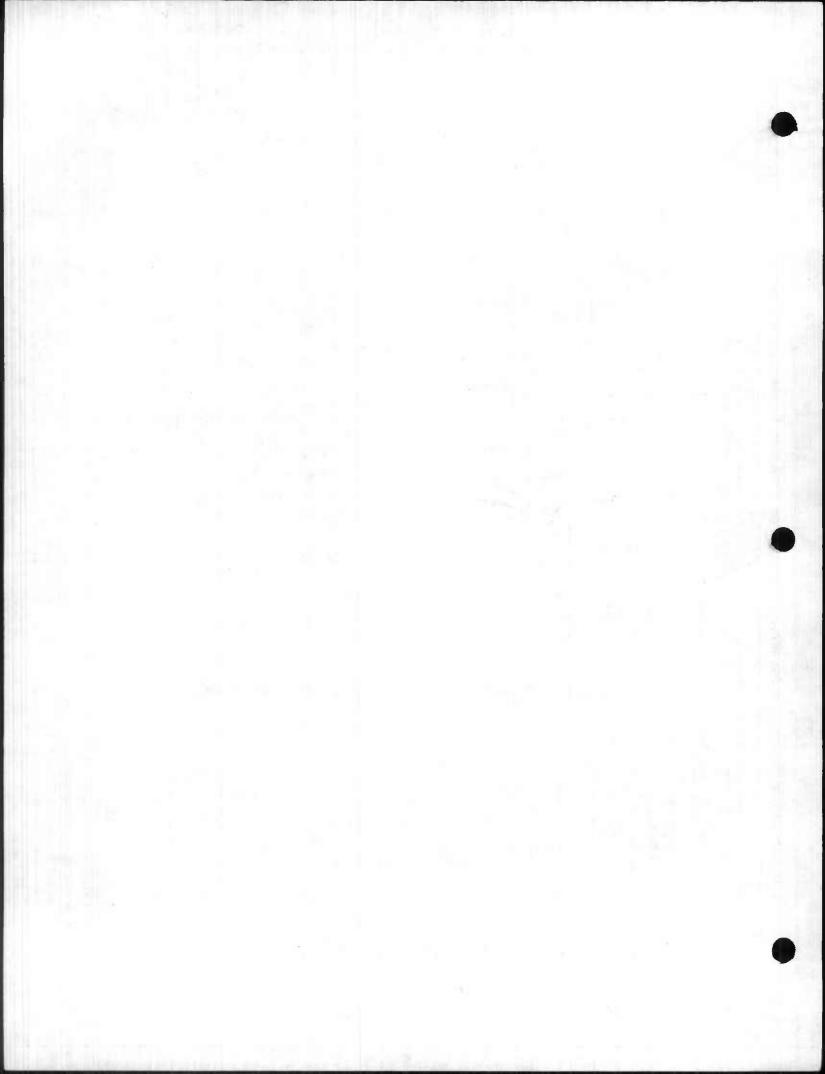
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedence Name (First, Middle, Last) 2. Data of Death Month **Physician** ANUAZI 2:57pm /Medical street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner NA 24 Hrs If Unday 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Security Number **Funeral** Days Hours 1□M 2QF 60 216-38-7311 Yrs. Director 01-05-40 MD Usual Residence of Decedent 10a. Stafa 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow MD NA Baltimore NOWes 2 No Director 289-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or must be 4406 Bowley's Lane Apt.#3-B 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. attac 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Trimmer London Town Manf. 11th Grade NA permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important; if Nem 27 is marked other any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ag Greenberry W. Howard P. Dorsey Irene 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 928 N. Durham Street Baltimore, MD 21205 Rita Jordan+Darlene Jordan 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Ramoval from Stata Oaklawn Cemetery 01-21-2000 Dundalk, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a Part1. Entar tha disease, or shock, or heart faiture. List that caused the death Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a corp Physician/Medical 82 the attending 980 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen page 2 : 1 Yes 28 No 1 ☐ Yes 2 No certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No Certification: To 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA this After thi funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral completely filled in the funeral completel 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Namé and addre ss of person who 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State JAN 2 Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** ALTHIA JONES AM Jan 16 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner BonSecour Hospital Baltimore NA 5. Social Security Number If Under 1 Year 6. Sex 7. Age (in yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 218-76-0917 41 Yrs. Director 12-06-58 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Inciting at MD Baltimore Mas 2 No Directo 10e. Street and Number 10l. Zip Code 10g. Citizen of What Country? 'natural', or hams 23s or dical Examiner must be r 5810 Gist Avenue 21215 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② (3/No If Yes, Giva Year or Dales: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Never Married 2 ☐ Married 1 ☐ Yes 2 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) NA Elementary/Secondary (0-12) 12th Grade S.S.I. Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 80 it. Pages 1 and 2 should be urbment of Health and Mental riant: if Nem 27 is marked o Pinkney Jones Katie Askin M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Atkins 4 Eden Rock Court Baltimore, Maryland 21208 Lula Μ. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 01-22-2000 Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service License 23a. Putt 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. WM.C.March FH 1101 E. North Avenue Approximate Interval Batween Onset and Death to not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical pticema Examiner Due to (or as a consequence of): Examiner anema attending physician and for use as the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nds tale new a edical Phyaician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? hes cartificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Hipatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 1 No this 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred edical Certification: After 5 Pending investigation 1 SNatural efter death. Director: Aft d in by the fur 1 Yes 2 No 2 Accident 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 | Homicide To the Hoepital of within 24 hours of To the Funeral Discompletely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

å

72 hours after

Baltimore, Maryland 21215-0020

the death certificate be assented

Box 68760

P.O. 1

Records,

of Vital

Division

or Attanding Physician:

DHMH 16 Rev 6/95

29b. Signature-eqd title of certifier

30. Name and address of perso

31. Data filed (Month, Day, Year)

GEBRE

MOGES

4660Wilken

who completed cause of death (Item 23a) (Type, Print)

32. Registrary Signature

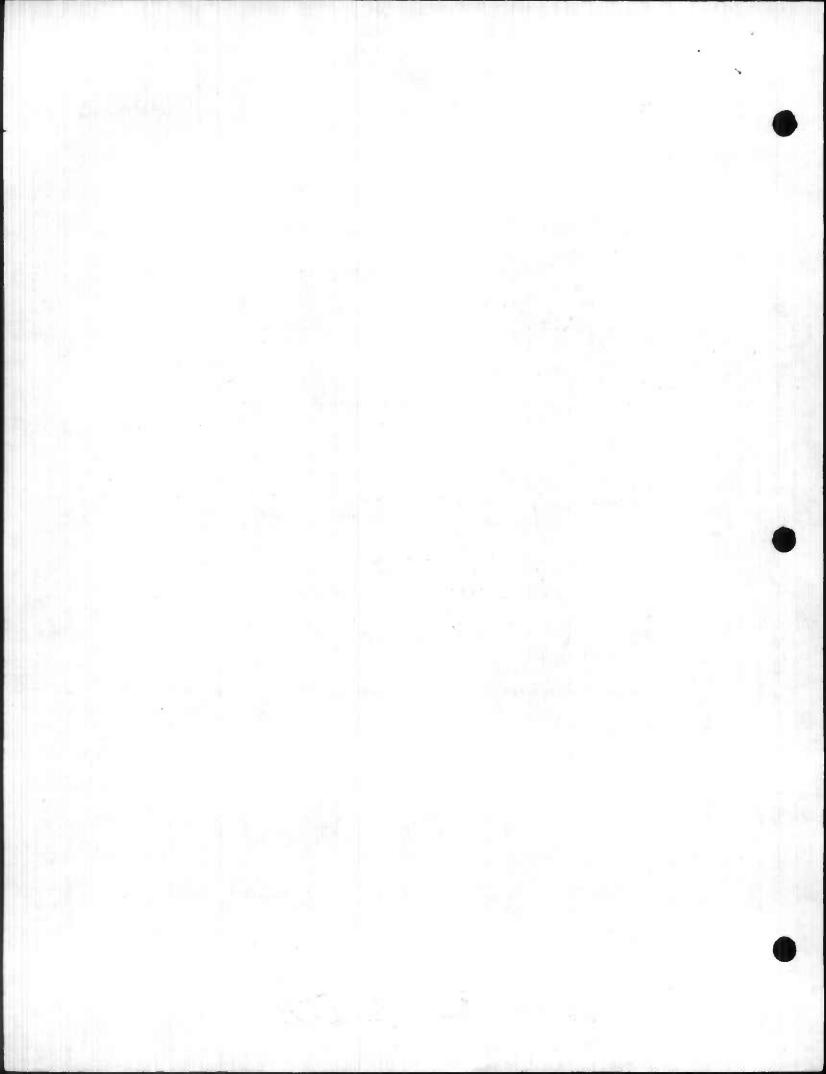
TARIA A.

29c. License number

D18327

29d. Data signed (Month, Day, Year) 1-16.00

Av Rack 21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4:35 AM **Physician** KAVLICH MARGAREI 2000 18 JANUARY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARATAN HOSPITAL BH Itimura NIA (500D) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F Yrs. 212-52-7943 Director AUG 25, 1915 Usual Residence of Decedeni 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Nas 2 No Directo SALTIMOre NIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or literia 23a GreenHill 21206 U.S.A 5628 AVE Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: WHITE ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiens. College (1-4or 5+) Home Housewife NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) a Pages 1 and 2 should be nent of Health and Mental Department of Health and Menta Important: If Nem 27 is marked any Injury or other traumatic av ance. WIDDICK MARY MORA 20 JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET . A. 406 2757 Greene LAR BALDWIN, MD 2 1013 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 121/2000 1 Deurial 2 Cremation 3 Removal from State BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) Centery PARKLIOOD 22. Nama and Addrass of Facility
HARTLEY Miller 21. Signature of Funeral Service Licensee. Funeral Home CHTD 7527 HARFORD BAITO MD RD. 23a. Partt. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final INTRACEREBRAL Massive BLOOD disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Hypertension physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): been signed by the a should be deteched f Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 20 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? 5 Panding invastigation 1 Natural e Hospital or Attending 24 hours after death. • Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcida 28e. Place of Injury - Al home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one)

Registrar DHMH 16 Rev 6/95

State

altimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

JAN 21 2000

DOMINGUE MOLL

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 5601 Loch RAVEN BOULDARD

29b. Signature and title of certifler

31. Date filed (Month, Day, Year)

32. Registrar's Signature

14 D.

BALTINOR

29c. License number

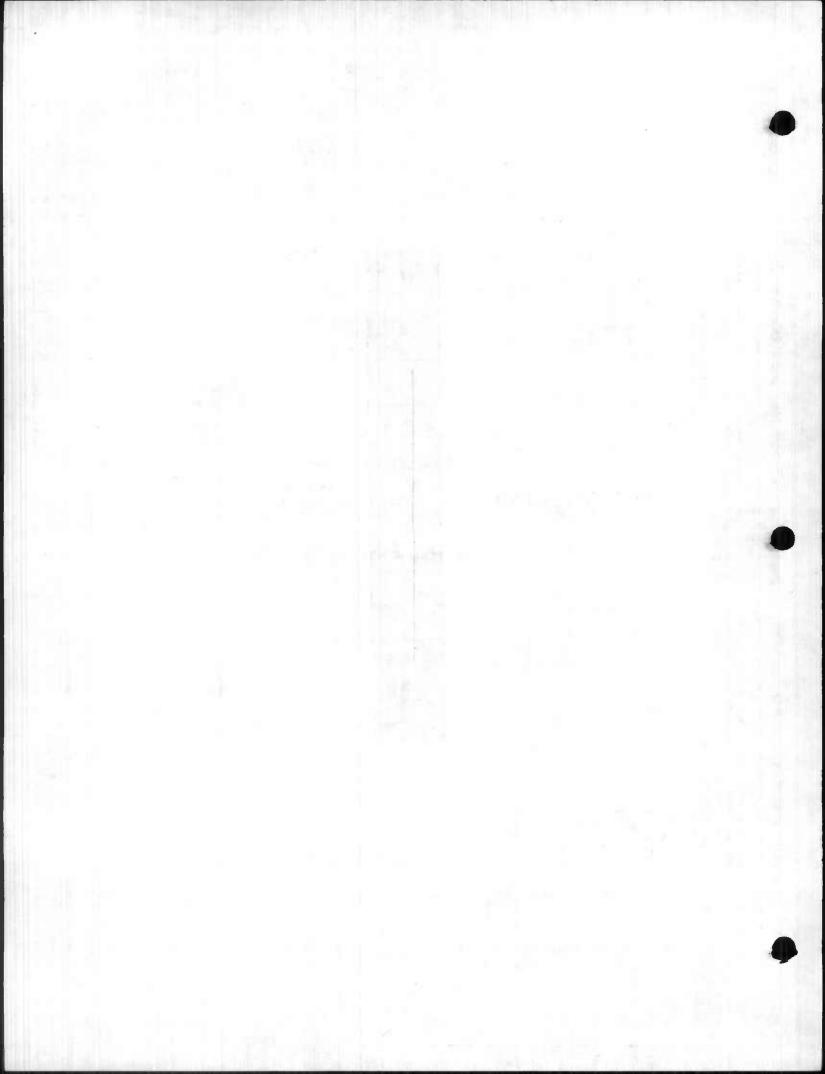
P13455

DomiNique

Good

29d. Date signed (Month, Dey, Year)

SAMAKATAN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month end31ersk1 4a. Facility Name (If not institution, give street and number) 2000 JANUARY 18 /Medicai 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 921 Rose ELKRIDGE MEDDOW HOWARD Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10M 20 F Days 212.78-295 Yrs Director SEPT 22, 1961 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinat must be notified at ELKRIDGE HOWARD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Rose MEADOW 21075 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 210 No Specify: Specify: à white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "n any injury or other traumatic avant Elementery/Secondary (0-12) College (1-4or 5+) 12+4 B.G+E COMPANY MANAGER NA 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) harles G. Kendgierski DOLORES JIRSA 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shura A. Kendzierski ELKRIDGE MD 5921 MEADOW ROSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 1/25/2000 BALTO MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery HARTLEY Miller Funeral Hame. CHTD.

527 HARFORD PD, BALTO. AD 21234

at the mode of this such that 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility 7527 Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, rock, or heart fallure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Metastatic Esophageal Cancer 21 months Examiner Due to (or as e consequence of) Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menney of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide nin 24 hours a the Funeral D Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Oncologist Johns Hopkins KHEath NO D 50753 January 21, 2000 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Johns Hopkins Oncology Center 600 North Wolfe Street Baltimore, MD 21287

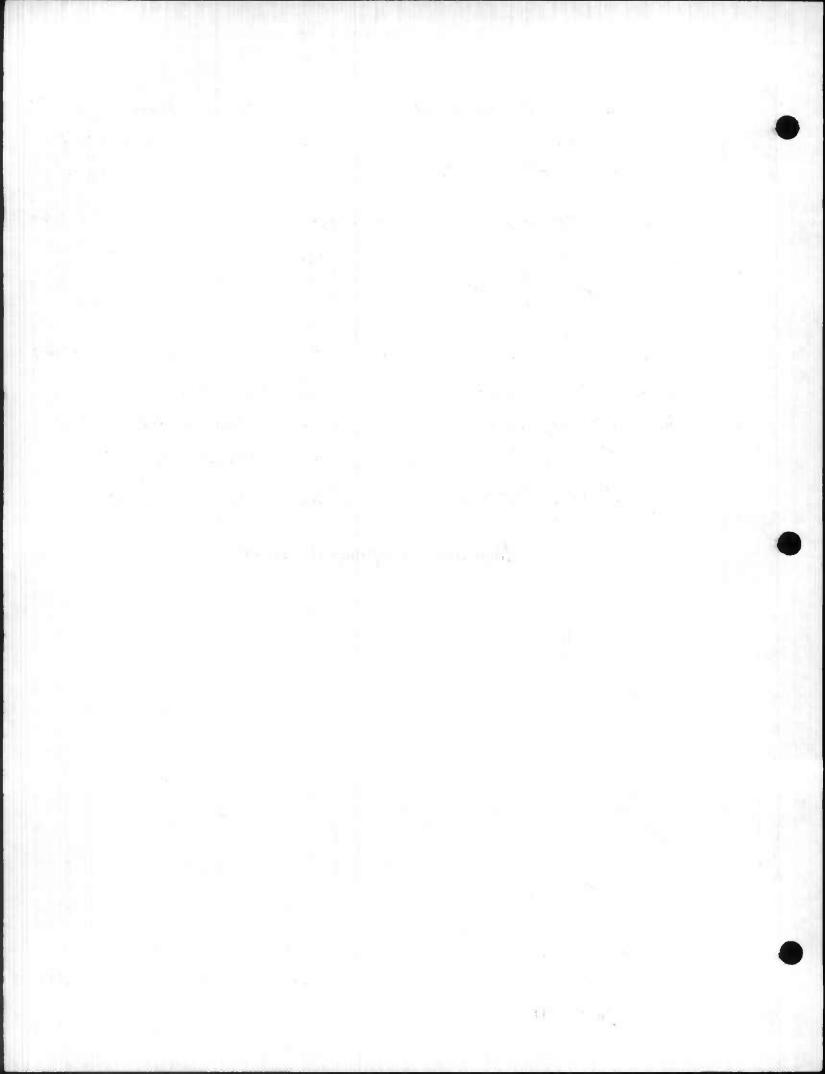
State Registrar

. . . .

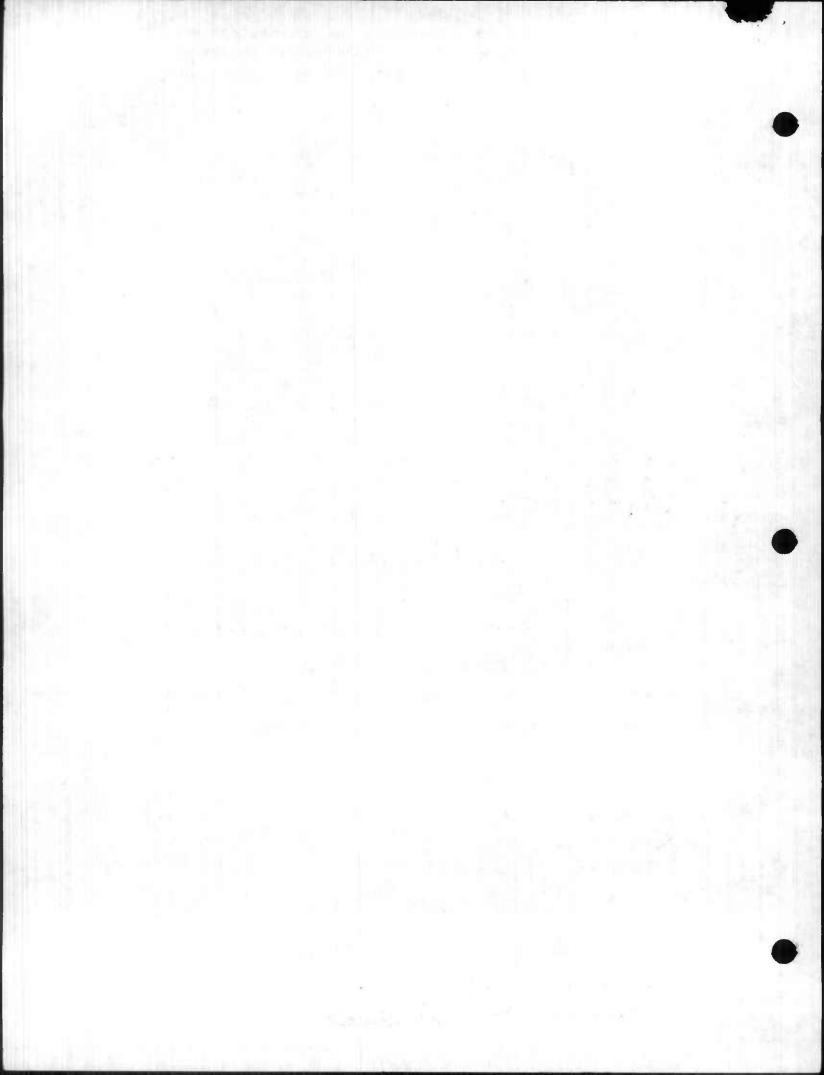
32. Registrar's Signature

Elisabeth Heath HO

31. Dete filed (Month, Day, Yeer)

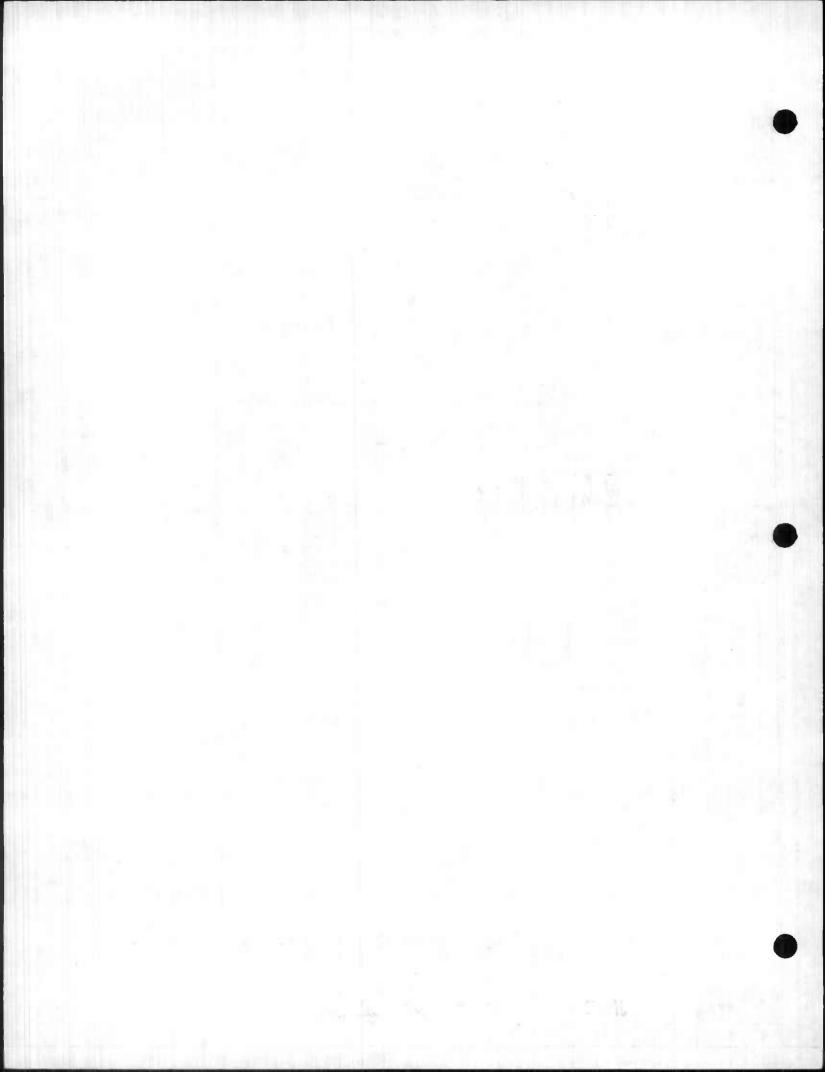


	d. Danadanila Na	Common Mindello I and	State of Ma	iryianu /		cate of		2. Data ot De	Reg. No.	0 0	11363				
Physician	Inderjit	me (First, Middla, Last	NMN	Kaur				Month	Day	Year	3. Tima of Death				
/Medical		(If not institution, give		Naui			4b. City, Town, or I	Location of Deat		of Death	815am				
aminer	Sinai	1 2 4 2	Himore				thaltimore		n/a						
eral ctor	5. Social Security 051-42-12	Number 6 Se		(In yrs. last		Under 1 Yaar onths Deys		8. Dala of Bir (Month, Da	a of Birth nth, Day, Year) 9. Birthplaca (Stata or Fore Country) ember 26, 1926 Rangoon, Burma						
-0	Usual Rasidance	1						TAX CITE	1.20,1200						
	10a. Stata	10b. County	10c. City, Town or Location							10	od. Insida City Limits 1 Yas 2 No				
Examiner must be notified at by Funeral Director	MD Baltimore Lutherville							10g. Citizan of What Country?							
						Of. Zip Coda									
eral		18 Tenby Court 11. Meritei Stetus 12. Was Decedent Ever in			21093 n U.S. 13. Was Decedent of Hispanic Origin? (S It Yas, specify Cuban, Maxican, Puert			nacify Vac or N	Burma	Id. 14. Rece - Amarican Indian,		-			
by Funeral	11. Meritei Stetus 1 Nevar Ma 3 Widowed	Armed Forcas? 1 Yes 2X N If Yas, Give Yaar or Datas:	Yes 2X No is, Give 1 ☐ Yas 2 X			Specify:	Black, White, atc. Specity: Asian								
Completed	/Co	ecation	16a. Decedent's Usual Oc			cupation		16b. Kind ot Businass/Industry							
nple	(Specify only highast grada complated) Elamantery/Secondary (0-12) College (1-4or 5+)			+)			during most of word)	Kirig							
		12		Homemaker					Own Home						
To Be	Surjar	e (First, Middla, Last)	Sinc					lama (First, Middla, Meldan Sumama) Kaur							
-	19a. Intorment's	Name/Reletionship (T)	vpe, Print)	1			end Number or Ru				Code)	-			
	Dr. Nip	oun Merchant/	grandson	1	8 Tenby	Court	Luth	erville,	Maryland 2	21093					
	20a. Mathod of D	isposition 2 □Cramation 3 □ F	Pamoual from State	20b. Place cema	ot Disposition	n (Nama of ry or othar ple	ice)	Data	20c. Location -	City or Tov	wn, State				
	4 Donation	5 Other (Specify)			p Serv.			/19/2000	Towson						
1000	21. Signeture of I	Funeral Sarvice Licens	tephen D. Co	ster		ma and Addre York Ro	ass ot Facility RUC Dad		Funeral Ho laryland 2°		nc.				
n al er	shock, or he Immediata Causi disaasa or condi resulting in death	ion	a. Seurae	Meta	Aconsequand	eidoc's					Approximata Intarval Batween Onset and Death				
Examiner	Sequantielly list of	conditions,	b. Necroti		a consequence	ca of):	.4 1	, ,		1					
E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that believed event of the conditions)														
dicai	rasulting in death) Last Due to (or as a consequence ot):								/						
Me			o Atrial	tibril	MoitA										
clar						7									
by Physician/M	Pert II. Other sign	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Grennary Astery Disease						23b. Did tobacco use contribute to the cause of death? 1 Uses 2 No 3 Probably 4 Unknown							
d by								24a. Was an autopsy 24b. Ware autopsy tindings							
Completed								performed? available p		nileble prior to					
Com								10	Yes 20 No	1 🗆	Yas 20 No				
Be	25. Was case refeaxaminar?	-				•		ath (Check only	ona)						
10	1 Yas 2	ZINO	fospitel: 1 Inpatiar			L DOA		4 Nursing Homa 3 Li Hasidenca 6 Li Other (Specify)							
ation:	27. Mennar of De 1 Neturel 2 Accident	ath 5 ☐ Panding Invastigetion	28a. Deta of Injur (Month, Day		b. Tima of Injury	28c. Inju Wo	ryet rk?]Yes 2 ☐ No	28d. Dascribe	how injury occur	red					
Certification:	3 ☐ Suicida 6 ☐ Could not be determined 28a. Placa of Injury - At homa, tarm, street, factory, offica building, atc. (Specify)						28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)								
edicai (29a. Certifier (Check only one)		sician: To the best of ner: On the basis of and mennar ste	examination											
Medical Certification: 1	29b. Signature ar	d title of certifier				29c. Licen	se number		29d. Data signe	d (Month, L	Day, Year)				
	D Alb	willing Mr				RE	Smo /Au	0 8797	Danna	~u 17	2000				
	30. Neme and ad	dress of person who co		11	a) (Type, Print	11 -1	1		77000	7	1				
	31. Deta filed Mo	VIST. Day-Yeleri	12	r's Signature	ENSINS	PIOSA 1	*/								
State	JA	N 2 I Z000	Zana Comment	- 7	1										



State of Maryland / Department of Health and Mental Hygiene 0 0 1 3 6 4

	Certificate of L	Death Reg. No.	01004						
	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death						
hysician /Medical	William Henry Kohnken	Month Day January 18 2	Year 1000 1:45 am						
xaminer	4a Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death 4c. Count							
	Anne Arundel Medical Center	Annapolis Anne	Arundel						
eral tor	5. Social Security Number 578-42-4875 6. Sex 1 N M 2 F 66 7. Age (In yrs. last birthday) Wonths Days	Hours Min. 8. Date of Birth (Month, Day, Year) April 12,1933	9. Birthplace (State or Foreign Country) New York						
	Usual Residence of Decedent								
rector	MD Anne Arundel Deale		10d. Inside City Limits 1 ☐ Yes 3(1)No						
al Director	10e. Street and Number 10f. Zip Code 6007 Melbourne Avenue 20751	10g. Citizen of USA	What Country?						
by Funeral	Armed Forces? If Yes, specify Cuba	n, Mexican, Puerto Rican, etc.) Bla	ce - American Indian, ck, White, etc. cy: White						
eted	15. Decedent's Education 16a. Decedent's Usual Occupe (Specify only highest grade completed) (Give kind of work done of	during most of working	usiness/industry						
Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 Outside Sales		Electric						
Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumai	ne)						
0	Frederick A. Kohnken	Regina Veronica Cassi	dv						
-	19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	and Number or Rural Route Number, City or Town	*						
		e Avenue, Deale, Maryla							
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location 01/19	- City or Town, State						
	4 □ Donation 5 □ Other (Specify) Metro Crematory		ore, MD						
	- I DAAN	ssorecumy Funeral Home, P.A. Ly Avenue, Annapolis, M	D 21401						
	23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart tailure. List only one cause on each line.	g, such es cardiac or respiratory arrest,	Approximate Interval Between Onset and Death						
il r	Immediate Cause (Finel disease or condition resulting in death) a. Cancreatic	Cancer	2 month						
Je Je	Due to (or as a consequence of):								
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Medical	Due to (or as a consequence of): d.	Due to (or as a consequence of):							
clan			1						
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23b. Did tobacco usa co	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
by		24a. Was an autopsy	as an autopsy 24b. Were autopsy findings						
Completed		performed?	available prior to completion of cause of death?						
Ö		1□ Yes 2□No	1 ☐ Yes 2 ☐ No						
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
10	1 Yes 20 No Hospital: Nampatient 2 ER/Outpatient 3 DOA Other	er: 4 Nursing Home 5 Residence 6 Ott	ner (Specify)						
	27. Mapmer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury Work 28c. Injury Work 28c. Injury	y all 28d. Describe how injury occu k? Yes 2 □ No	rred						
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Num City or Town, State)	ber or Rural Route Number,						
edical	29a Centiling Physician: To the best of my knowledge, death occurred at the time (Check and Check and Chec	ne, date and place, and due to the cause(s) end m pinion, deeth occurred at the time, date end place,	annar as stated. and due to the cause(s)						
M	29b. Signature and althe of certifier 29c. License	e number 29d. Date signe	ed (Modth, Day, Year)						
	H.D. Palsemi), D	26743 1/1	8/00						
4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HD. Goldstein 1 MD. 205 Rd	dyely Ave Ar	inapelis m						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature 4. Angul	, /							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death JANUARY 19, 2000 2:28 AM HARRY KORSOVER 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 24 Hrs. | 8. Da BALTIMORE If Under 1 Year 8. Data of Birth (Month, Day, Year) 6. Sex. 1 AM 2 F 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) Days Hours Months Yrs. 216-05-6616 85 SEPT.13,1914 Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? 2711-A HANSON AVENUE #1-D 21209 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Wes Decedent Evar in U,S. Armed Forces? Bleck, White, etc. XYas 2 No fYas, Give 1 Never Merried 2 Married 1 ☐ Yas 2 X No Specify: Specify WHITE 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) INVESTIGATOR STATE OF MARYLAND 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) JOSEPH KORSOVER ROSE SODY 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) LILLIE KORSOVER / WIFE 2711-A HANSON AVENUE #1-D, BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata OHR KNESSETH ISRAEL ANSHE 1/20/00 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Entar tha disadsa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Acula MIT Immediate Cause (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, landing to immediata ceusa. Entar Underlying Cause (Disease or Injury that initiated avants rasulting In death) Last Dua to (or es a consequence of): Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DNO 1 ☐ Yas 2 ☐ No 1 Yas 25. Was case refarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 1 Inpatiant 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 Yas 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be execu Box 68760, signed by the atte Records, P.O. page 2 certificate Division of Vital or Attending Physician: this After death. within 24 hours after deat To the Funeral Director:

Examiner Physician/Medical þ Completed 8 Certification: To

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

28a-f

ò

Nerns 23s

filed within 72 hours after

. Pages 1 and 2 abouid be in ment of Health and Montal H lant: If Item 27 is merked off jury or other traumatic even

Department of Important: If any injury or

Physician

/Medical

Examiner

Baitimore, Maryland 21215-0020

27. Manger of Death

1 Natural 2 Accidant 3 Suicide

29a. Certifier Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. (Check only one) 29b. Signeture and title of

29c. Licensa number

29d. Data signed (Month, Day, Year)

31. Data filed (Month, Day, Year)

30. Name and address of person ompleted cause of death (Item 23a) (Type, Print) IMPERIAL BY

State Registrar

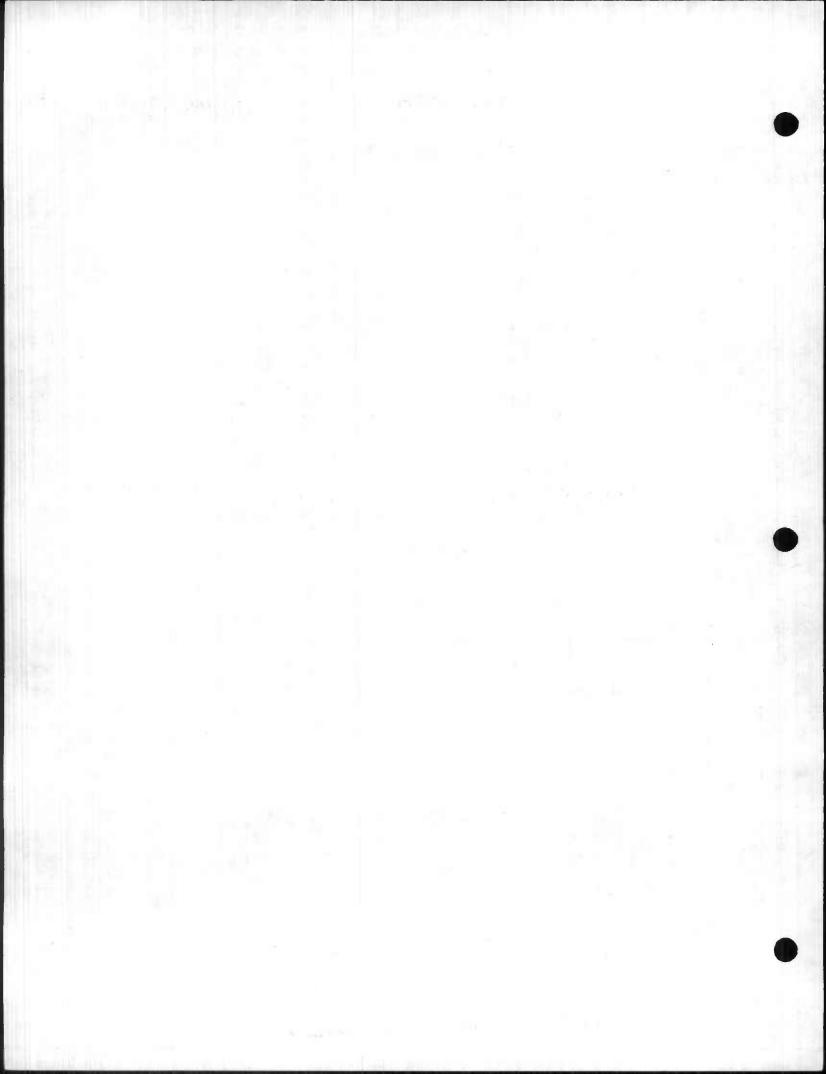
DHMH 16 Rsv 6/95

filled in by

Medical

the Hospital

32. Registrar's Signatura

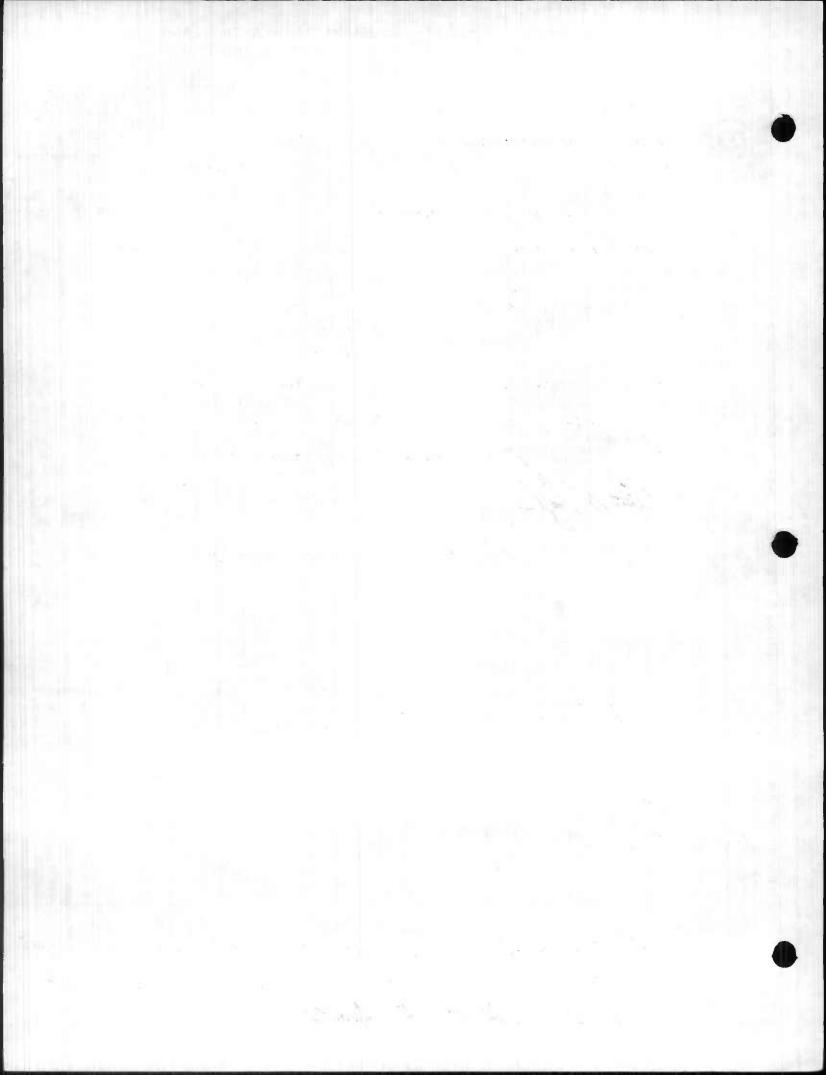


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** paue ancis anuary /Medical #c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 49 Yrs 217-56-5068 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any Inlury or other traumatic event, me Middle Example mortland any Inlury or other traumatic event, me Middle Example mortland. 10e. State 10b. County 10c. City, Town or Location 10d. fnslde City Limits MD Baltimore Baltimore 1 ☐ Yas 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6150 Radecke Avenue 21206 U.S.A. Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Cable Traffic Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Francis J. Knauer Sr. Betty Jo Bogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Ralationship (Type, Pnnt) Bie Chiu Knauer 6150 Radecke Avenue Baltimore, Maryland 21206 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gardens of Faith Cemetery 1/22/00 Baltimore, Maryland 22. Neme end Address of Fecility John C. Miller Inc. 21206 6415 Belair Road Baltimore, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician /Medical fmmediate Causa (Final disease or condition resulting in death) Examiner Dua to (or as a consequence ot) Physician/Medical Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? ed by the a signed by t Vascular 10 Yes 20 No 3 Probably 4 Unknown dia þ 24b. Were eutopsy findings aveilable prior to been si 24a. Wes en eutopsy performed? Completed completion of cause of death? page 2 s 1 Yes 2 19 No 1 Yas 2 No certificate the Hospital or Attending Physician: director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) examinar? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 DER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannacot Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, tarm, street, fectory, office building, atc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida edical 29a. Certifier 1 🖵 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and due to the causa(s) and mannar as stated 22 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) end manner stated. 29b. Signeture end title of contilion 29c. License number 29d. Date signed (Month, Day, Year) who complated cause of death (Itam 23a) (Type, Print) 30. Name and address of

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



permit. Pages 1 and 2 should be file Department of Health and Merstal Hyg important: if fleen 27 is marked other any injury or other transmented other 9866. **Physician** /Medical Examine the death certificate be executed physician and the burial-tran Box 68760. 88 980

P.O.

Records,

of Vital

Division Attending

The law requires

this

After

death.

after

6

Physician

/Medical

Examiner

Funeral

Director

28a-f show

8 must be

Norms 23a

8

'natural'

Hygiene. Other than

96

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

ģ

Completed

Be

Examiner Physician/Medical ò signed t g Completed page 2 s Be Certification: To funeral Director: / To the Hospital within 24 hours a To the Funeral Completely filled

edical

Allen Segal, M.D. 31. Data filed (Manus, Day, Zeas)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 200 No 27. Manner of Death 120 Natural 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homleide EXEcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and tipe of pedifier 29c. License numbe 29d. Date signed (Month, Day, Year) D52261

State Registrar

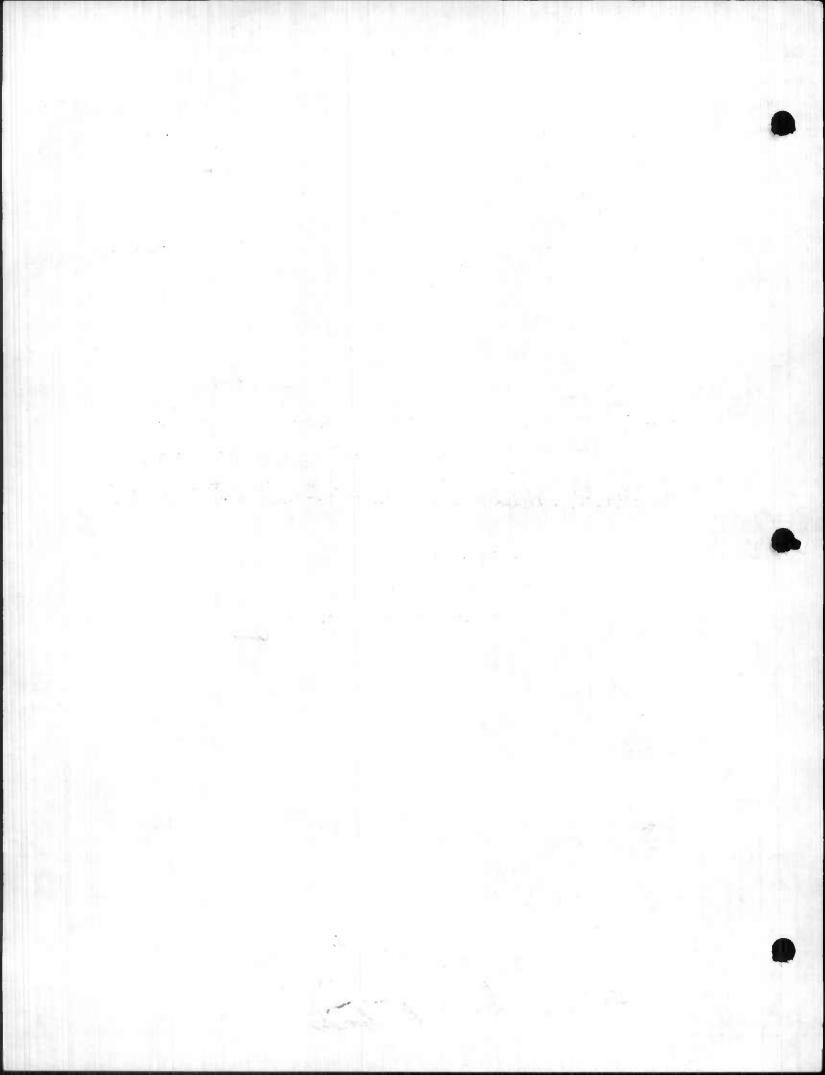
DHMH 16 Ray 6/95

1299 Lamberton Drive, Silver Spring Maryland

30. Name and address of person who completed cause of death (from 23a) (Type, Frint)

M

January 20, 2000



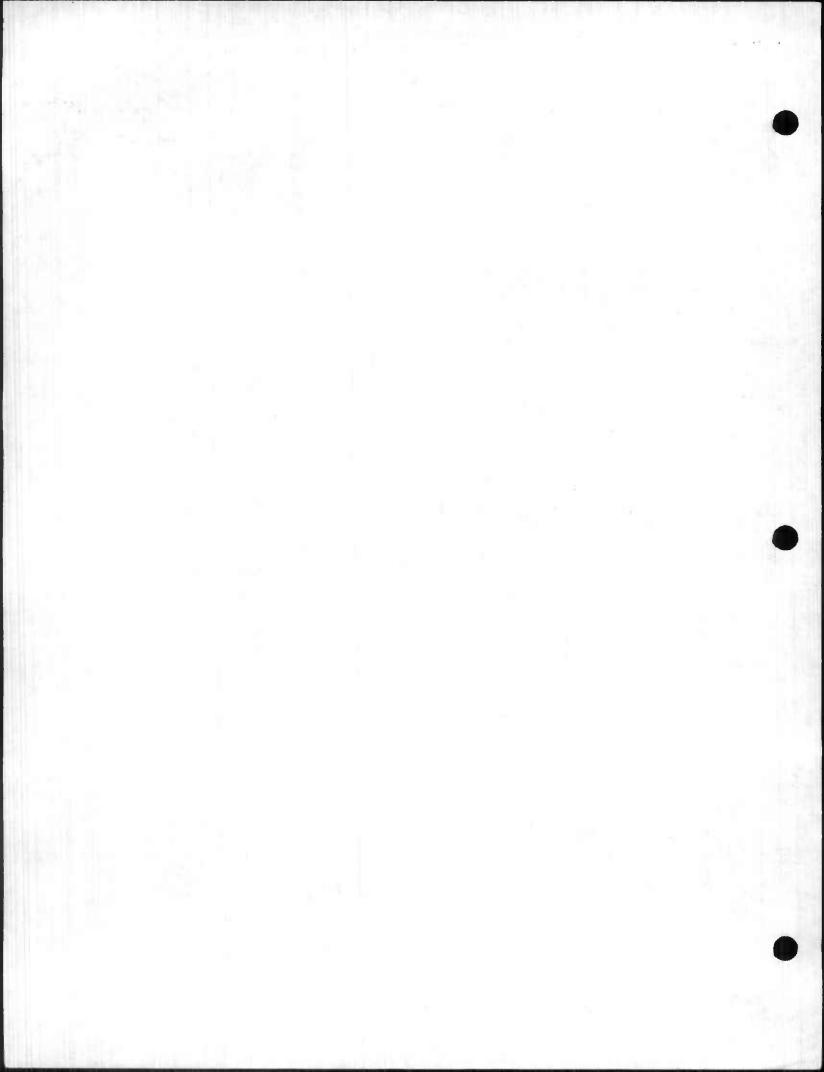
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decadent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** Lundaren John Arnold 2000 4:14 PM 13 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 10 M 2□ F Months Days Hours Yrs. 037-07-3204 Director July 2, 1912 MASS Usual Residence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-4 show 1 Yas 2 No Baltimore Directo Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tal Hygient.
d other than "natural", or items 23e or event, the Medical Exeminer must be 13801 York Road 21030 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married white altimore, Maryland 21215-0020 1 Yes X□XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within nent of Health and Mantal Hygiens, int: If item 27 is marked other than 1 Elementary/Secondery (0-12) College (1-4or 5+) C.P.A. Accounting 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be John A. Lundgren Alice V. Widlund 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 13801 York Road Elsa J. Lundgren/wife Cockewille, MD 21030 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State important: if its any injury or oth 2023 20e. Method of Disposition 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 01/22/2000 Attleboro, Mass. 22. Name end Address of Fecility 1050 York Road Stephen Coster Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23e. Pert1. Entel the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical MULTI LOBAL PNEUMOUIR 1 WGGIC Examiner Due to (or as e consequence ot): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot) Box 68760. Due to (or es a consequence ot) P.O. I Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detact MULTI INFANCT D6MGUTIA Division of Vital Records, g 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy periormed? Completed Chource FIBRULATION Marine 2 1 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes aptial or Attending Physician: The norm after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 28e. Date of tnjury (Month, Dey Year) 27. Manyler of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Plece of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and menner stated. 29e. Certifier edical 29c. License number 29d. Dete, signed (Month, Dey, Year) 29b. Signeture end title of certifier D33011 recedelel 00 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) YORK ROL COCKEYSUILLI COBGRI WILDGFGG Mal KD 2000 Registrate Signature

DHMH 16 Rev 6/95

State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#26 perPhyG779 1/21/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** ELLEN LINGLE January
4b. City, Town, or Location of Death 2000 5. 5:30 PM * /Medical 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Genesis Elder Care Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Yrs. Director 235-46-4629 Sept 27, 1927 unknown Usual Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits 10a State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryla Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 802 W. Ostend Street Funeral 21230 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes _2 ☐ No If Yes, GivA Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: À 3 ₩ Widowed 4 Divorced Completed Coparmit. Pages 1 and 2 should be filed within 72 h. Qopariment of health and Mental Hygierie.

Firsportant: If flem 27 is mericed other than "natual they injury or other traumedic event, the Medical Otics. 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 nurse medicine 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be unknown unknown 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Genesis Health Care 802 W. Ostend Street Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in stste 22. Neme and Address of Facility Ronald S. Wade. Director

State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner Tultple the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events and certificate be execu Box 68760. attending physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 98 980 for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, P.O. signed by it 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificata has 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 28e. Dete of Injury (Month, Dey Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury at Work? Certification: After 1 Maturel 5 Pending death. 1 TYes 2 No Investigation 2 Accident after death Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. 29a. Certifler (Check only one) within 2 To the 29b. Signeture and title of certific 29c. License number 29d, Date signed (Month, Dev. Year) Attensing 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SchWARTZ M.D. E. Meleose 115 Arenne 32. Registrar's Signature State BASILA Registrar

MUSTE

HILDER WILL STREET

5877 9010

Water British Company

Eremital of Haller

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 1 15 **Physician** MANNING WILMA E. 01-PM /Medical b, City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner # 901 NIA BALTIMORE PARK DRIVE DRUID If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yaar) Birthplace (Stete or Foreign Country).

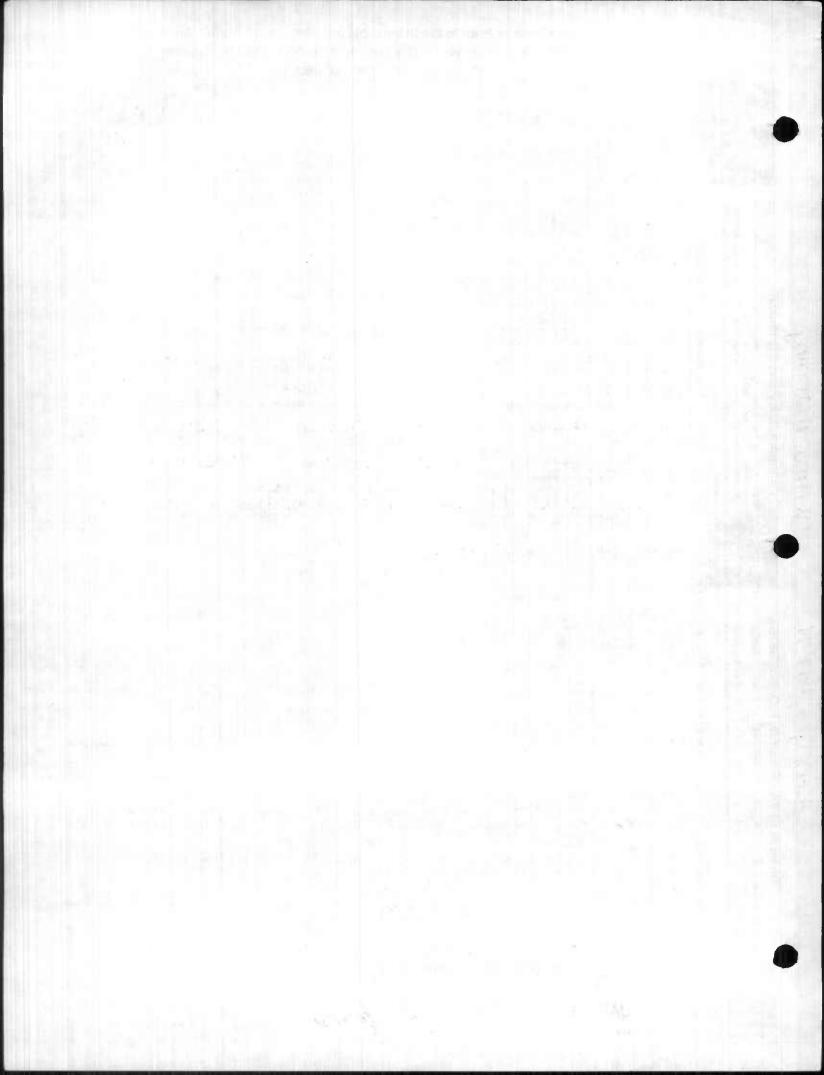
VA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2回F Months Days Yrs. 224.40.7778 Director Usual Residence of Dacadent 10b. County 10c. City, Town or Location 10a. Stafa 10d. inside City Limits 1 Yes 2 No NIA Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 traumatic event, the Medical Examiner must be DRIVE Ветя 23а PARK # 901 21217 USA 111 DRUID Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ፫ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14 Race - American Indian 11. Marital Status Biack, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: ò Specify: BLACK þ 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Wilma Manning Elementary/Secondary (0-12) College (1-4or 5+) NA (JUARD 11 TH GRADE 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be on and Mental) JAMES MASON KOSS MABLE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2. Bepartment of Health a myourtant: If Item 27 is STREEPER ST. BALTO DANIELLE MANNING N mo. 20b. Place of Disposition (Neme of cematery, crametory or other plece) 20c. Location - City or Town, State 20a. Mathed of Disposition 1 Ø Burial 2 □ Cremation 3 □ Removal from State ö 4 □ Donation 5 □ Other (Specify) 1-22-2000 VALENTINE . VA EMETERY 21. Signature of Funerat Sarvice Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE any it 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or humilimiter. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Carcinoma disease or condition resulting in death) Lkamine Examiner pue Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequance of): physician Physician/Medical the Due to (or as a consaquanca of): USB for Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? detached signed by t d be detach 1 Yea 2 No 3 Probably 4 JUnknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was cese referred to medical Be 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury af Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 [] Natural 5 Panding after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 29a. Certifier 1🗹 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medicai 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 1-18-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 N. Eritaust Balloud 200

State Registrar N 2 1 2000

C

Kobart

Irwin Mo 32. Registrar's Signature Leneva



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** deo 2000 Jan 16 pm /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner # ? h Birthplace (State or Foreign Kimari 5. Social Security Number If Under 1 Y 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Maryland Months Days Hours Min 218-12-4115 Usual Residence of Decedent Yrs. Director 10d. Inside City Limits 10b. County 10a. Stata 10c. City, Town or Location 28a-f show the Maryta must be notified at 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? E S ĕ 2/050 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Berns 23a by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Meritai Stetus wes Decedent Ever in U.S. Armed Forces? 1 News 2 No If Yes, Give Year or Dates: W Black, White, etc. event the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Merried 2 Merried 21215-0020 à 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced "naturs!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Md. State Police Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Lol Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nd Mental I marked of la m 19b. Meiling Address (Street and Number or Eyral Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) if them 27 is or other tra ropost Md JORMA FRANCIS Baltimore, Jan. 20 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State Department of the control of the con Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS Funeral Chapel - BED LIR 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. 2105C Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical week SEPSIS Examiner Due to (or es a consequence of) Physician/Medical Examiner 1 YEAR CANCER PANCECAMIC use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. be detached 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Medical Certification: To Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should certificate has 1 Yes 280No 1 Yes 2□ No within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, or Attending Physician: 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29a. Certifier (Check only onel 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

StateRegistrar

31. Date filed (Month, Day,

80

DHMH 16 Rev 6/95

MD

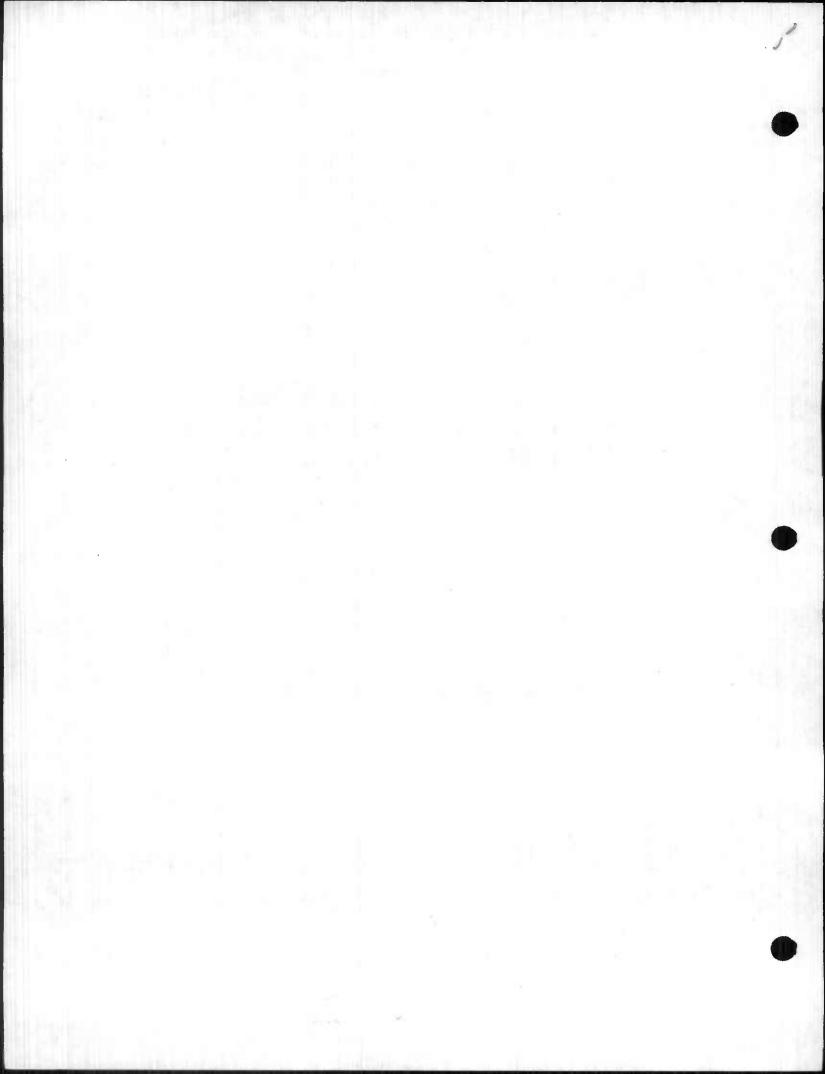
32. Registrar's Signature

30-Name and address of person who completed gause of death (Item 23a) (Type, Print)

D53335

JANUARY

19,2000



Registrar

State

TOWSON, MD 21204

7601 OSLER DRIVE,

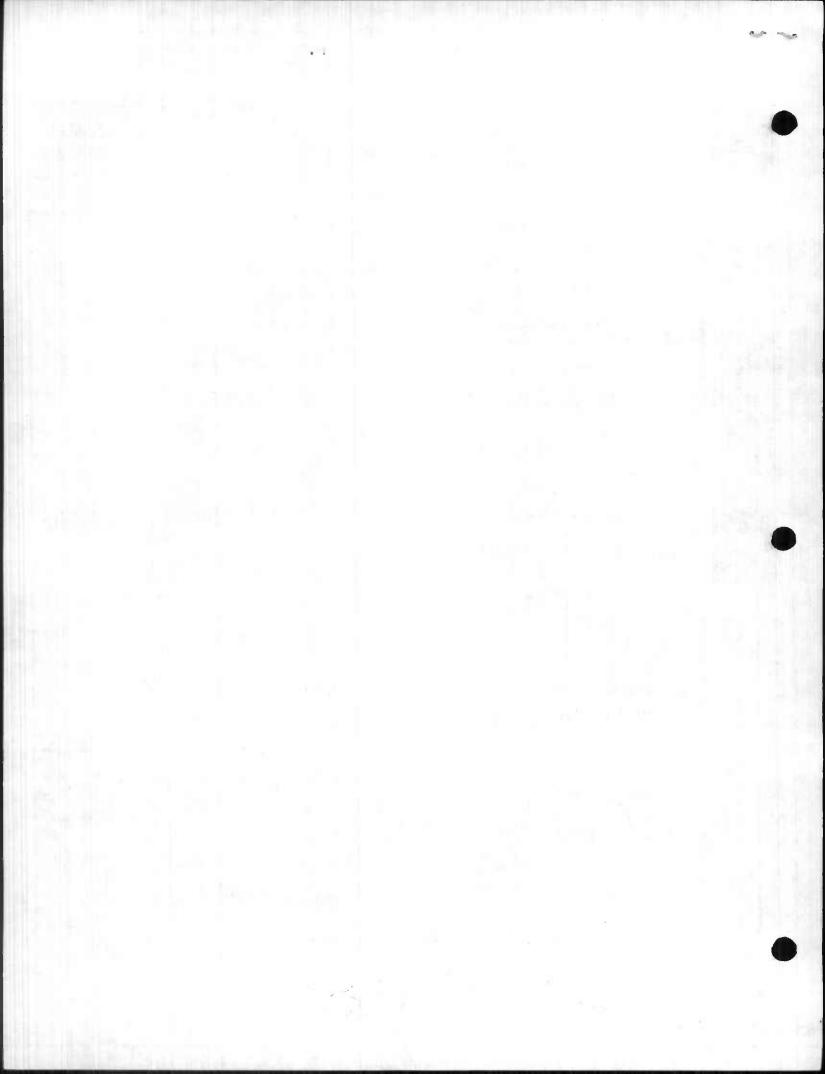
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D. ,

LIM,

31. Dete filed (Month, Day, Year) JAN 2 1



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First, Middle, Last) 2. Date of Death 3. Time of Death 735 Year **Physician** anuary 2000 /Medical 4b. City, Town, or Location of Dealth 4a Facility Name (If not institution, give street and number 4c. County of Death Examiner oita. ylana nera 8. Date of Birth (Month, Day, Sex 1MM 2DF If Under 1 Year (In yrs, last birthday) 9. Birthplace (State or Foreign Country) 7. Age Months Days Hours Min. 212-48-1080 Usual Residence of Decedent Yrs Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside Oty Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zlp Code 10g. Citizen of What Country? 10e. Street and Number 234 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 Married 1 Never Married nd Mental Hygiene. marked other than "natural", or altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced american Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) Morris, Thomas 16b. Kind of Business/Industry 15. Decedent's Education Etementery/Secondary (0-12) College (1-4or 5+) 17. Fatherts Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and Mental H Be Mailing Address (Street and Number or Rural Route Number, Informant's Name/Relationship (Type, Print) City or Town, WU Department of Health Important: If item 27 is 20b. Placa of Disposition (Name of compteny, crematory or other) Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, Stete any injury or T₅ □ Other (Specify) 4 Donetion 21. Signature of Funeral Service Licensi 23 art 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** tmmediate Cause (Finat disease or condition resulting in deeth) /Medicai **Examiner** Examiner physician and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): 81 for use 23b. Did tobacco uss contribute to the causs of death? Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormed? Completed peen After this certificate has 2 12 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturet 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptaca of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as steted. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tenri Nammour Mo

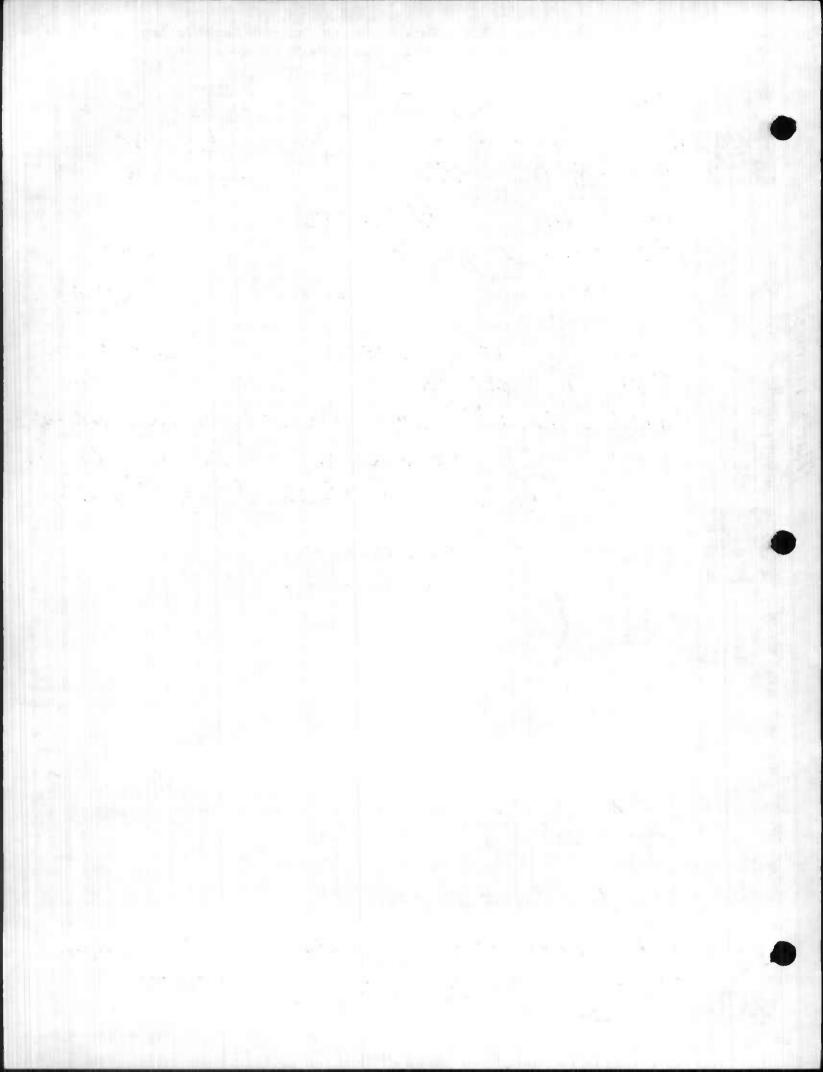
Maryland

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Henri Nammour, M. D. Go Mary la

32. Registrer's Signature

Nam mou

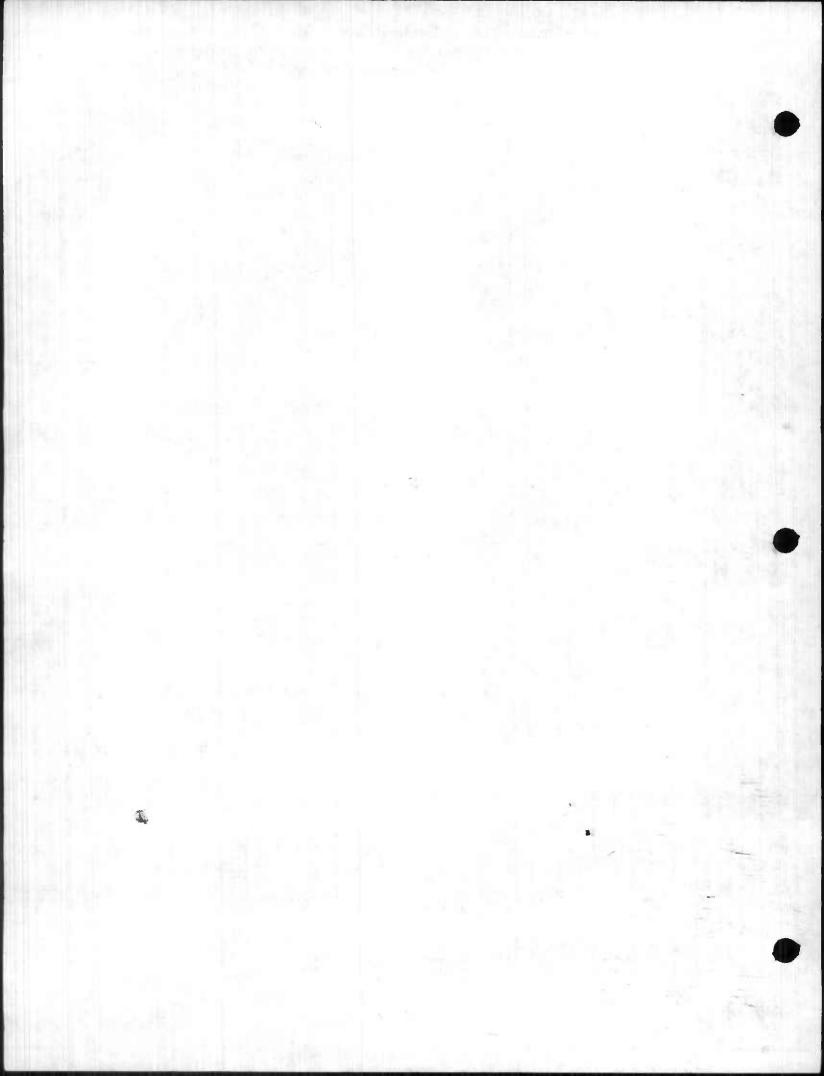
31. Date filed (Month, Day, Year)



ician dical	1. Decedent's Name (First, Middle Jacque in	e, Last)	I. A	layo)		2. Date of De Month JANUAI	PAY 13, 2	Year 3. Tima of Death 17:50 P
	4a Facility Name (If not institution BOWIE HEALTH C			1		4b. City, Town, or	Location of Deatl		of Death
	5. Social Security Number 229-94-3613	6. Sex 1 ☐ M :	20 F 7. Age (n yrs. last birth	dey) If Under 1 Yes Months Day			th year 62	9. Birthplace (State or Forei
_	Usual Residence of Decedent 10a. State 10b. County	1/1	1	Oc. City, Town	or Location		,	/	10d. Inside City Limi
Funeral Directo	ICAN SY Junia	V/A	CCino	thi!	10f. Zip Code	1/2	DE A	10g. Citizen of V	
-	11. Meritel Stetus	95e.	Ves Decedent Every Forces?	r in U,S.	13. Was Decedent of the Yes, specify Control of the Yes, s	of Hispanic Origin? (Specify Yes or No)- 14. Rac	e - American Indian,
	1 Never Married 2 Marri 3 Widowed 4 Divorced	ied 1	Yes, Give		1 ☐ Yes 2 N		nto riican, etc.)	Specify	ck, White, etc.
-	15. Decedent (Specify only highes	t's Education	n npleted)	(Decedent's Usual Occ Give kind of work dor	ne during most of w	orking	16b. Kind of Br	usiness/Industry
	Elementary/Secondary (0-12)	C	college (1-4or 5+)	In	ite: DO NOT use ret	n Coed	ialist	La	e W
1	17. Father's Name (First, Middle, I	Last)	1/ 1/		TO THIS TO	18. Mother's Ne	eme (First, Middle	, Maiden Sumer	10)
	Leonard	V	V. Ma	40		Vir	ginia	E,	spence
	19a. Intermant's/Name/Relationsh	hip (Type, P	is-Ma	117 46	Meiling Address (Stre	ger end Number of F	10 AUG	Phil	State, 210 Code)
-	20a. Method of Disposition 1 Disposition 2 Cremation	2 🗆 🗆 🗆		20b. Place of I	Disposition (Neme of cremetory pr other)	Slece)	Date /	20c. Location -	City or Town, State
	4 Donation 5 □Other (Sp	pecify)	val from Stele	Whit	e Chap	el Garden	\$ 124 pago	reaste,	rville, Pa.
	21. Signature of Funeral Service L	Licensee	200	11/	To South	dress of Facility	s. Fun	eral.	Home
	ANGLER	/ ~	. / //.	11/1		N. II	-1	W-Ota	111 1 1 1 1 1 1
+	23a. Part . Enter the disease, or	complication	ns that ceused th	e death. Do no	2222 U	tylng, such as cardi	ec or respiretory a	rrest,	Approximate
	23a. Part . Enter the disease, or shock, or hear failure. List	complication only one can	AMED CA	DDION		OMYOPATHY		-1	Onset and Death
	Immediate Ceuse (Final disease or condition	complication only one can	AMED CA	RDIOM		OMYOPATHY AND REGI	URGITAN	-1	Onset and Death
	Immediate Ceuse (Final	complication only one can bill a	ATED CA	RDIOM VA	TED CARDIO	OMYOPATHY AND REGI		-1	Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions,	DIL &	ATED CA	RDIOM VA	TED CARDIO YOPATHY LVE ANOM	OMYOPATHY AND REGI		-1	Onset and Death
- 1	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	e	ATED CA	RDIOM VA	TED CARDION TED CARDION TO THE ANOM onsequence of):	OMYOPATHY AND REGI		-1	Onset and Death
-	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	e	ATED CA	RDIOM VA e to (or as a co	TED CARDION TED CARDION TO THE ANOM onsequence of):	OMYOPATHY AND REGI		-1	Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b c	ATED CA	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): insequence of):	OMYOPATHY AND REG	URGITAN	T MITR	Interval Between Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	b c	ATED CA	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): insequence of):	OMYOPATHY AND REG	URGITAN 23b. Did	T MITR	Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b c	ATED CA	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): insequence of):	OMYOPATHY AND REG	23b. Did	tobacco use co	Interval Between Onset and Death AL Interval Between of Death AL Interval Between of Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b c	ATED CA	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): insequence of):	OMYOPATHY AND REG	23b. Did	T MITR	Interval Between Onset and Death AL Interval Between Onset on Onset and Death Interval Between Onset on Onset on Onset and Death Interval Between Onset on Onset o
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b c	ATED CA	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): insequence of):	OMYOPATHY AND REG	23b. Did	tobacco use co	Interval Between Onset and Death AL Interval Between Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	e b c d ene contribut	Du Du ting to death but r	POLICE ARDIOM VA. e to (or as a co	TED CARDIC YOPATHY IVF: ANOM insequence of): insequence of): the underlying ceuse	OMYOPATHY AND REGIONALY given in Part 1.	23b. Did	tobacco use co Yee 2 No san autopsy ormed?	Interval Between Onset and Death AL Interval Between Onset and Death
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Last Part II. Other eignificant conditions.	e b c d Hospit	Du Du ting to death but r	e to (or as a co	TED CARDIC YOPATHY IVE: ANOM insequence of): insequence of): the underlying ceuse	OMYOPATHY AND REGILATION ALY given in Part I. 26. Place of D Other: 4 \(\text{Nursing} \)	23b. Did 1 □ 24a. Was performed to the control of t	tobacco use co Yee 2 No sen autopsy ormed? Yes 2 No one) idence 6 Oth	Interval Between Onset and Death AL Intribute to the cause of deat 3 Probably 4 Unknown or to completion of ceuse of death? 1 Yes 2 No
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Part II. Other eignificant conditions.	e b c d Hospit	Du Du ting to death but r	e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): Insequence of): The underlying ceuse Patient 3 DOA The of 28c. In	OMYOPATHY AND REGILIANT RE	23b. Did 1 □ 24a. Was performed to the control of t	tobacco use co Yee 2 No s an autopsy ormed? Yes 2 No one)	Interval Between Onset and Death AL Intribute to the cause of deat 3 Probably 4 Unknown or to completion of ceuse of death? 1 Yes 2 No
	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Last Part II. Other eignificant conditions awaminer? 15_Ves 2 \(\) No 7. Menner of Death \(\) Anturel \(\) Pending	e b c d Hospit getion not be	Du Du ting to death but r	e to (or as a co	TED CARDIC YOPATHY IVF. ANOM insequence of): Insequence of): The underlying ceuse Patient 3 DOA The of 28c. In	OMYOPATHY AND REGIONALY given in Part 1. 26. Place of D Other: 4 Nursing	23b. Did 1 1 24a. Was performed to the control of t	tobacco use co Yee 2 No san autopsy ormed? Yes 2 No one) idence 6 Oth how injury occur	Interval Between Onset and Death AL Intribute to the cause of deat 3 Probably 4 Unknown or to completion of ceuse of death? 1 Yes 2 No
Cerification: 10 be Completed by Physician/Medical	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Part II. Other eignificant conditions aximiner? 1	b	Du Du ting to death but r la. Date of Injury (Month, Dey Y) be. Place of injury building, etc. (in: To the basis of ex	e to (or as a co	TED CARDIC YOPATHY Nesequence of): Insequence of): Ins	OMYOPATHY AND REGIONALY given in Part 1. 26. Place of D Other: 4 Nursing niury et Nork? Yes 2 No ce	23b. Did 1 24a. Was performed to the cath (Check only). 28t. Location (City or To cae, end due to the	tobacco uae co Yee 2 No san autopsy ormed? Yes 2 No one) idence 6 Oth how injury occur (Street and Numb	Interval Between Onset and Death Onset (Specify) One of Capacity Onset (Specify) Onset (Specif
legical Certification: 10 be completed by rhysicial/wedical	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying that initialed events resulting in deeth) Last Part II. Other eignificant conditions axaminer? 1 1 Yes 2 No 27. Menner of Death 1 Naturel 2 Accident 3 Sulcide 4 Homicide 1 Certifying (Check only one)	b	Du Du Du ting to death but r la. Date of Injury (Month, Dey Y building, etc. (e to (or as a co	TED CARDIC YOPATHY INTERPOLATION Insequence of): Insequence o	OMYOPATHY AND REGIONALY given in Part 1. 26. Place of D Other: 4 Nursing niury et Nork? Yes 2 No ce	23b. Did 1 24a. Was performed to the cath (Check only). 28t. Location (City or To cae, end due to the	tobacco use co Yee 2 No san autopsy ormed? Ves 2 No one) idence 6 Oth how injury occur (Street and Numb wm, State) cause(s) and me, dete end place,	Interval Between Onset and Death Onset (Specify) The Completion of ceuse of death? Interval Between Onset and Death Onset (Specify) The Completion of Course Onset (Specify) The Course Onset Onset (Specify) The Course Onset On
Medical Certification: To Be Completed by Phys	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Part II. Other eignificant conditions aximiner? 1	b	Du Du ting to death but r ting to death but r la. Date of Injury (Month, Dey Y) be. Place of Injury building, etc. (it: To the best of m on the basis of ex and manner stated	e to (or as a co	TED CARDIC YOPATHY Nonsequence of): Insequence of): In	given in Part 1. 26. Place of D Other: 4 Nursing niury et Vork? Yes 2 No ce	23b. Did 1 24a. Was performed to the cath (Check only). 28t. Location (City or To cae, end due to the	tobacco use co Yee 2 No san autopsy ormed? Yes 2 No one) idence 6 Oth how injury occur (Street and Numb wn, State) cause(s) and mo dete end place, 29d. Date signe	Interval Between Onset and Death Onset (Specify) The Completion of cause of death? Interval Between Onset and Death Onset (Specify) The Completion of Cause Onset (Speci

00-0227-033

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** January 11, 2000 on · /Medical 4b. City, Town, or Location of Death 4s Fscility Neme (If not institution, give street end number) 4c. County of Death Examiner General maryland Baltimore Nospital 8. Date of Birth (Month, Day, if Under 24 Hrs. 5. Sociel Security Number If Under 1 Year (In yrs. lest birthdey) Birthplece (State or Foreign Country) 10 M 20 F Months Deys Hours 213-30-244 Usuai Residence of Decedent Yrs. Director 10a. State 10b. Count 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No 7 is merked other than 'natural', or items 23s or 28s-f i traumetic event, the Medical Examinar must be notified Directo Ore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 15 Funeral 0 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. IPO NOT use retired) 16b. Kind of Business/Industry and Mental Hyglens. Elementary/Secondary (0-12) Coilege (1-4or 5+) rival 17. Fsther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 19a, informent's Name/Relationship (Type, Print Social) 19b. Melling Address (Street end Number or Rural Route Number, Pages 1 and 2 ,21 Health Hem 27 i 2 altimore, 20b. Place of Disposition (Name of elery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury 21. Signature of Funeral Service License 22. Name end Address of Facility Joseph Part | Enter the difference, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear rather. List only one cause on each line. W. North Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as e consequenca of): Box 68760 physician Physician/Medical 9 Due to (or es e consequenca of): 88 980 P.0. 23b. Did tobacco use contribute to the cause of death? Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 8 B 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, ğ 2 24b. Were autopsy tindings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed # page 2 2 1 No 2 PNo certificate director. 25. Was case referred to medical examiner? 88 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 12 Inpatiant 2 ER/Outpatient 3 DOA å 28e. Date of Injury (Month, Day Year) funeral 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation or Attending 1 Natural after death. 2 No 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) To the P within 2 To the P 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartitier 29c. License number uci 200

General Hospital

State Registrar

JAN 2 1 2000

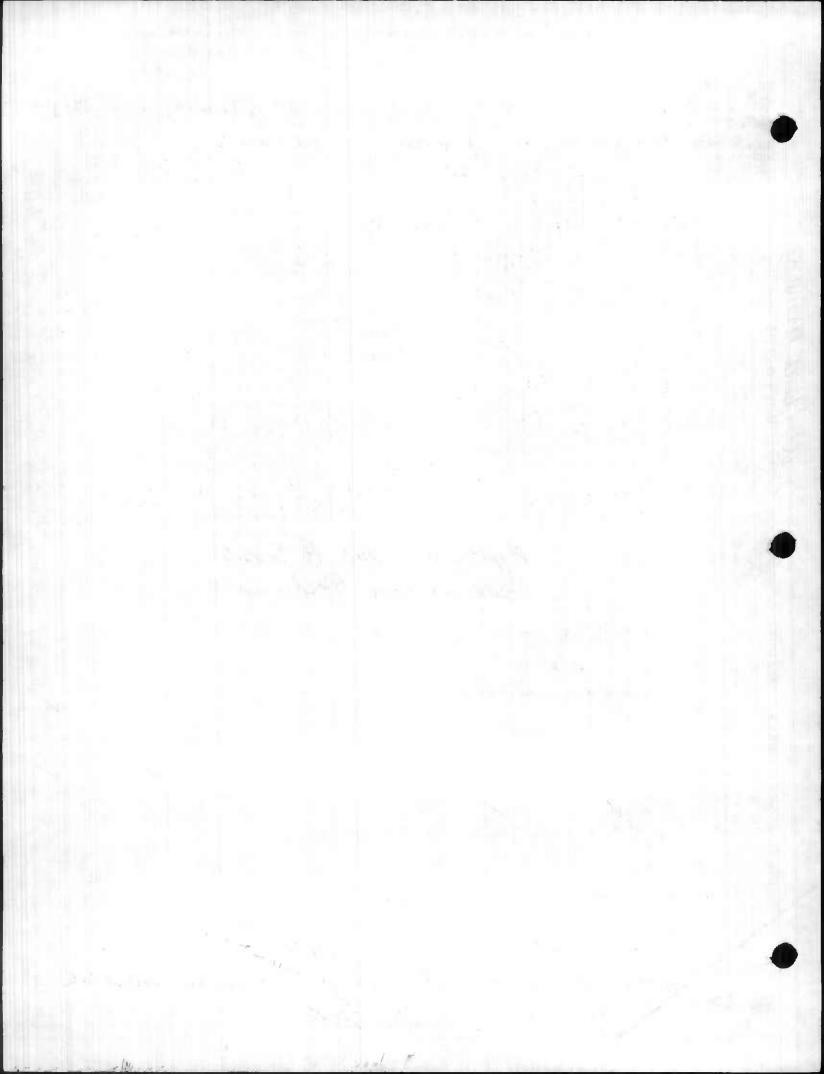
31. Dete tiled (Month, Dey, Yeer)

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

40

m.D.

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mess ick 6:50 pm Thane 2000 January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 31, 1945 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F Months Days Hours 202-36-7469 54 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Dauphin Middletown 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2055 North Union Street 17057 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 Merried 1 Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Partner Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marlin Messick Gladys Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Judy Messick/Wife 2055 North Union Street, Middletown, PA 17057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Ebenezer United Meth. Cemetery 101/22/00 Middletown, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Christina L. David 5305 Harford Road, Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Cancer -1/2 415 Problems/ Failure 2 weeks Due to (or as a consequence of) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Pulmonary Edema Iweek Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 XYes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Linpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1)KLYes 2□ No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined

Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, 88 for use þ Completed page 2 Physician: funeral director. Certification: To Be After this or Attending 24 hours after death. the filled in by

Physician

/Medical

Examiner

10s. State

PA

Directo

Funeral

þ

Completed

Funeral

Director

r 28a-f show notified at

8 must be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygienn. Important: If Item 27 is marked other than "netural", or the any injury or other traumatic event, the Medical Examples.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

the Marylan

the Hospital completely within 2

DHMH 16 Rev 6/95

State Registrar

Medical

MOUDED 31. Date filed (Month, Dey, Year)

3 ☐ Suicide

29a. Certifier

4 Thomicide

(Check only one)

29b. Signature and title of certified

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

Wolfe Street. 600 North

125-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

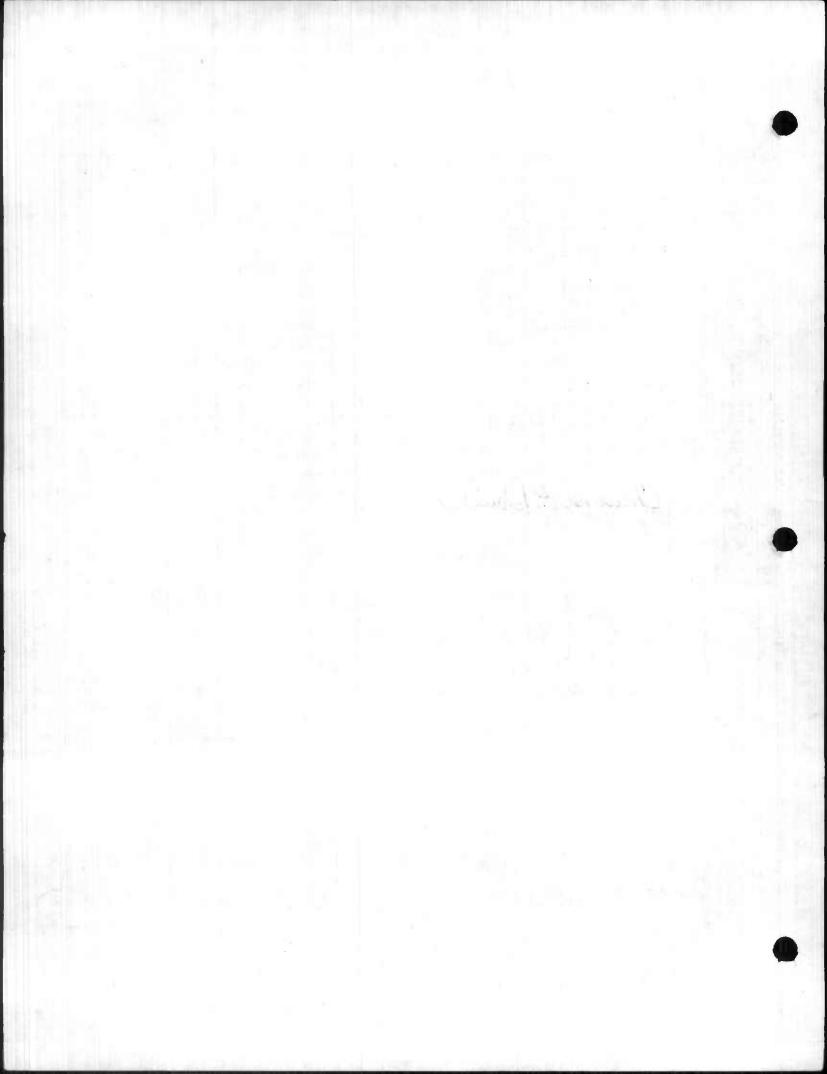
RES-000

ORIGINAL

29d. Date signed (Month, Dey, Year)

Baltimore.

17. 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Wonth Yea 18 2000 5:10 f.m Knuany Laverna E. Myrick 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours 1□ M 2♥ F 70 Yrs. 212-28-1880 May 7,1929 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yee 2 ☑ No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 7606 Ronnie Lane 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Francis Regina Reilly Samuel Gary 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) George J. Myrick -7606 Ronnie Lane, Pasadena, MD Husband 21122 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Jan. 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Marriotsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) Crestlawn Memorial Gdns. 2000 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signeture of Funeral Service Licens Sulta 12 Ridgely Avenue, Annapolis, MD μ∠ κιαgery Avenue, Annapolis 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Status Post cardiac arras Immediate Ceuse (Finel disease or condition resulting in death) Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Respirate-23b. Did tobacco use contribute to the cause of death? chance obstrative 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Lows Disease 1 ☐ Yes 2 ☐ No 1 Yes 2. No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA

Physician/Medical Examiner The law requires that the death certificate be executed bunial-trar Box 68760. USB 85 P.O. 3 Records. page 2 should be Be Completed certificate has Division of Vital or Attending Physician: director. this funeral After To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afti completely filled in by the fur

Physician

/Medical

Examiner

Funeral

Director

Nerna 23a or 28a-f show

ò

I Hygiene.

Department of Health and Important: If Nem 27 is ma any injury or other traums

Physician

/Medical Examiner

Pages 1 and 2 should

altimore,

Directo

Funeral

à

Completed

Be

2

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. λq 25. Was case referred to medical 1 ☐ Yes 2 ☐ No Medical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation Neturel Injury 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Tertifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

State Registrar

31. Date filed (Month, Dey, Year)

301 Hospity Donve

mo

Neme and addrass of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 1

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARY **Physician** 9:30a.m. 16, 2000 4c. County of Death JANUARY /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner n/a Baltimore Baxter Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-20-993 10 M 20 F Days Hours Yrs. Md. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or hama 23a or 28a-1 ahow any injury or other traumatic avant, the Medical Examinar must be notified at 10b. County 10d. Inside City Limits n/a 1 Yes 2 No Director 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D.No If Yes, Give Year or Dates: 14. Rece - American Indien 11, Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
(fig. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) urse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eva Taylor Jacob Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2818 W. Mosher Street Baltimore, Md. 21216 19a. Informant's Name/Relationship (Type, Print) Dorothy Blackmon cousin 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 KI Kremetion 3 □ Removel from State Thomas Cemetery Jan. 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, mo 21. Signature of Funeral Service Tittle 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the bank. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each time. Approximate Interval Between Onset and Deeth Physician END-STAGE RENAL DISEASE Immediate Cause (Final disease or condition resulting in death) /Medical 4 MONTHS Examiner Due to (or as a consequence of):

PERTENSIVE AND ARTERIOSCUEROTIC

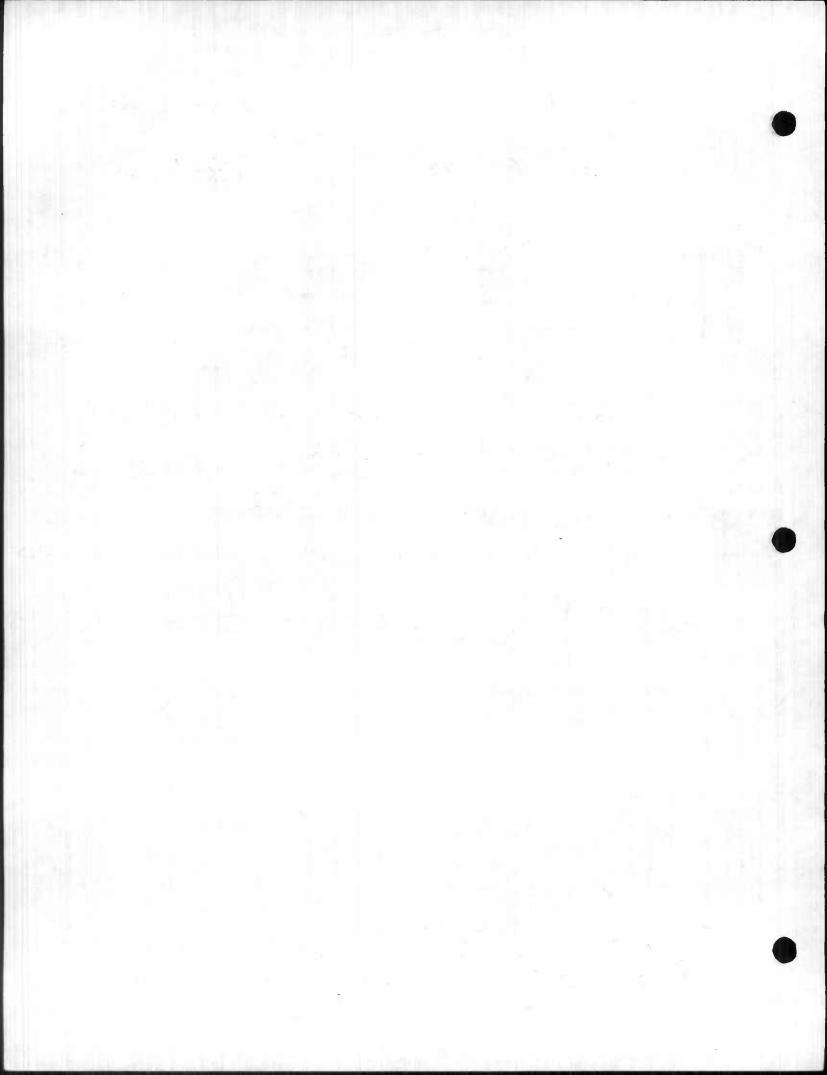
Due to (or as a consequence of):

CARDIO VASCULAR DISEASE Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNKNOW Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Pes t Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this : After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 29a. Certifier mination and/or investigation, is my opinion, deeth occurred at the time, date end place, and due to the cause(s)

| 29d. Daty signed (Month, Day, Year) (Check only one) ner: On the basis of exa 2300 GARRISON BLYD, BALTIMORE, MD. 21216 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item#31 perOVR G779 1/2\$/ate of Waryland / Department of Health and Mental Hygiene Amended Item#24a perPhyG779 1/21/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** Month Year Violet McCabe. Ann January 6, 2000 4:45 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3034} Pinewood Avenue Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Devs Hours 1 M 2 XF New Jersey 75 Director 140-18-4916 Oct. 30,1924 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland 28a-t N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be b 3034 Pinewood Avenue 21214 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 XNo
If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Bieck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White. Specify: à 3 XWidowed 4 ☐ Divorced Year or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Arthur Pinkerton Violet Denniston 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intorment's Name/Relationship (Type, Print) 1816 Edgewood Road, Baltimore, MD Mr. Timothy McCabe (son) 21234 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremetion 3 ☐ Remove from Stete Department limportant: If any injury or ance. Green Mount Crematory 1/10/00 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service License 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Parff. Enter the disease shock, or heert tailure complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner Autoriose bootie Adonneed ician and burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury the initiated events resulting in death) Last Due to (or as a consequenca ot). physician the burla Physician/Medical Due to (or es a consequence ot): USe as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 TYes 2 No been signed t should be det þ 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of death? page 2 1□ Yes 2 No 1 Tyes 2 No. certificate funeral director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After Netural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. or Attending Physician: 24 hours after death. Funeral Director: A To the Hospital of within 24 hours af To the Funeral Di Medical

Baltimore, Maryland 21215-0020

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29b. Signeture and title of certifier

29c. License number 29d. Dete signed (Month, Day, Year)

020607

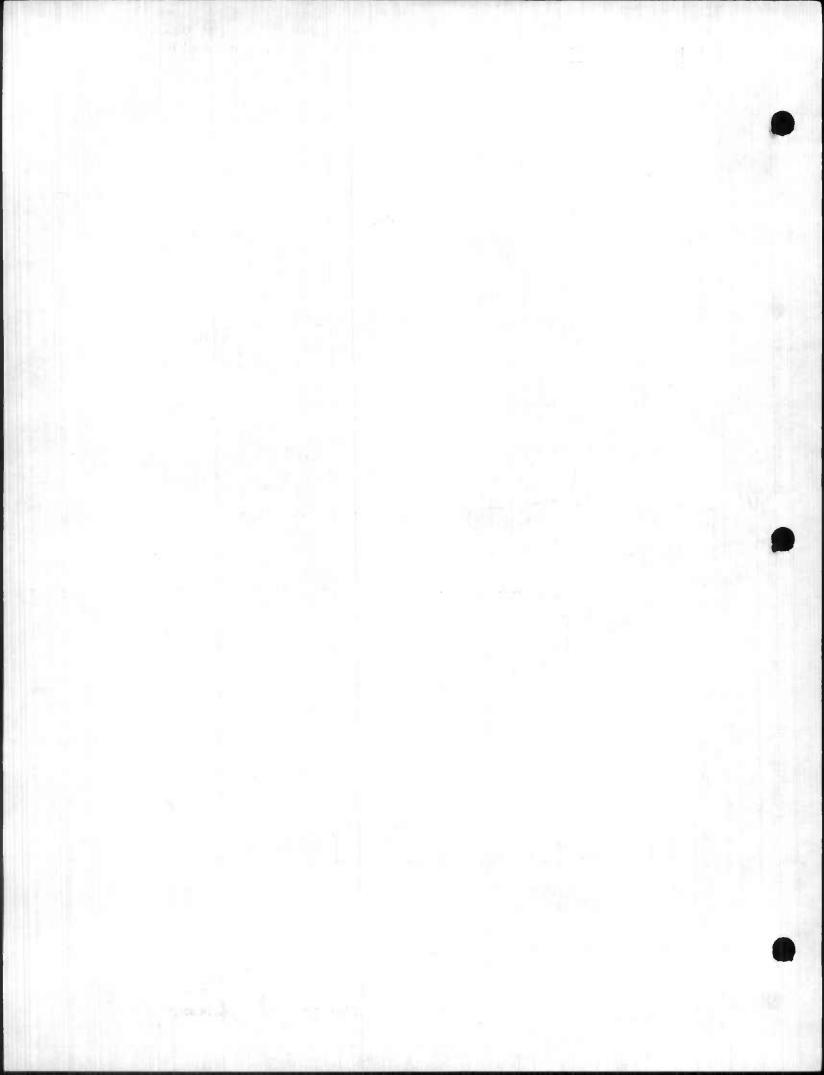
80110

30. Name and address of person who completed cause ot deeth (Item 23e) (Type, Print)

5 12. Chanlos 6701

State Registrar 31. Dete tiled (Month, Dey, Year)

32. Registrer's Signeture JAN 2 1 2000

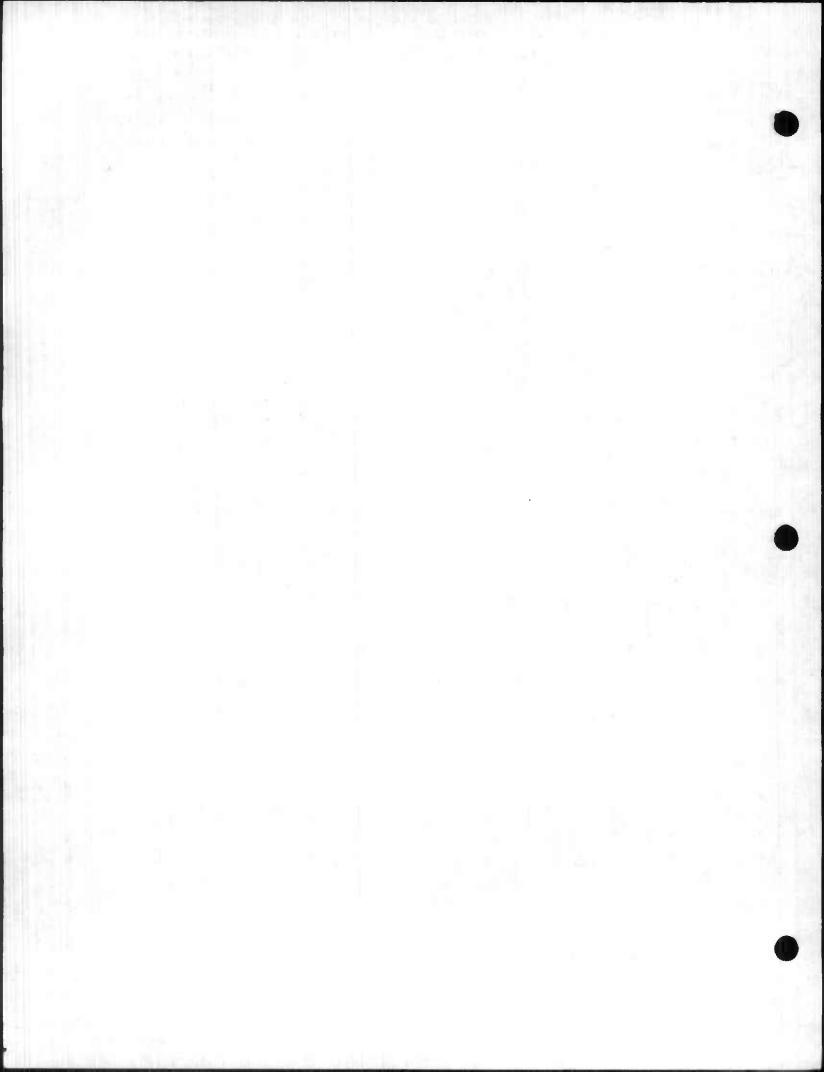


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day **Physician** 5:05 PM S. Mauck Margaret Jan. 2000 14, /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 411 Houcksville Rd. Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplece (Stata or Foreign
Country) **Funeral** 1□ M 21 F Months Days Hours Min MD 75 Yrs. 219-18-4383 1 - 19 - 24Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show MD Carroll Hampstead 1 Yes No Directo 10f. Zip Coda 21074 10e. Street and Number 10g. Citizen of What Country? USA Examiner munt be 411 Houcksville Rd. Hems 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 72 hours after 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or WW II 1 ☐ Yes 2 No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Hygiene. other than "natura ent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be flied within nent of Health and Mental Hygiene. ent: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Eppler Barrel Co. 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nema (First, Middla, Last) Be Margaret Schoenberger Sebastian Bodensteiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Houcksville Rd. Hampstead, MD 21074 Karl G. Mauck / son 20b. Place of Disposition (Name of cometery, crematory or other place)
Druid Ridge important: If its any injury or ob obse 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burlal 2 □ Cramation 3 □ Ramoval from State 1-19-00 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Ave. Rosedale, MD enibe Approximate triterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each hole. **Physician** fmmediete Ceuse (Final disease or condition resulting in death) /Medical Acute Myocardial Infarction Examiner Due to (or as a consequenca of): Physician/Medical Examiner attending physicien end for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequença of) Box 68760, Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yee 2 No 3 Probably 4 Unknown yd bengis Hypertensive Cardiovascular Disease Division of Vital Records, ò page 2 should be 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica
Corgletely filled in by the funeral director; p. 25. Was case reterred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 1 Yes 2 No 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29d. Data signad (Month, Day, Year) 29b. Signature and titla of contact 29c. Licansa number ندر 2000 30. Name end address of person who completed cause of death (tem 23a) (Type, Print) Faustino, M.D. 4111 Lower Beckleysville Road Hampstead, 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Jenera Registrar



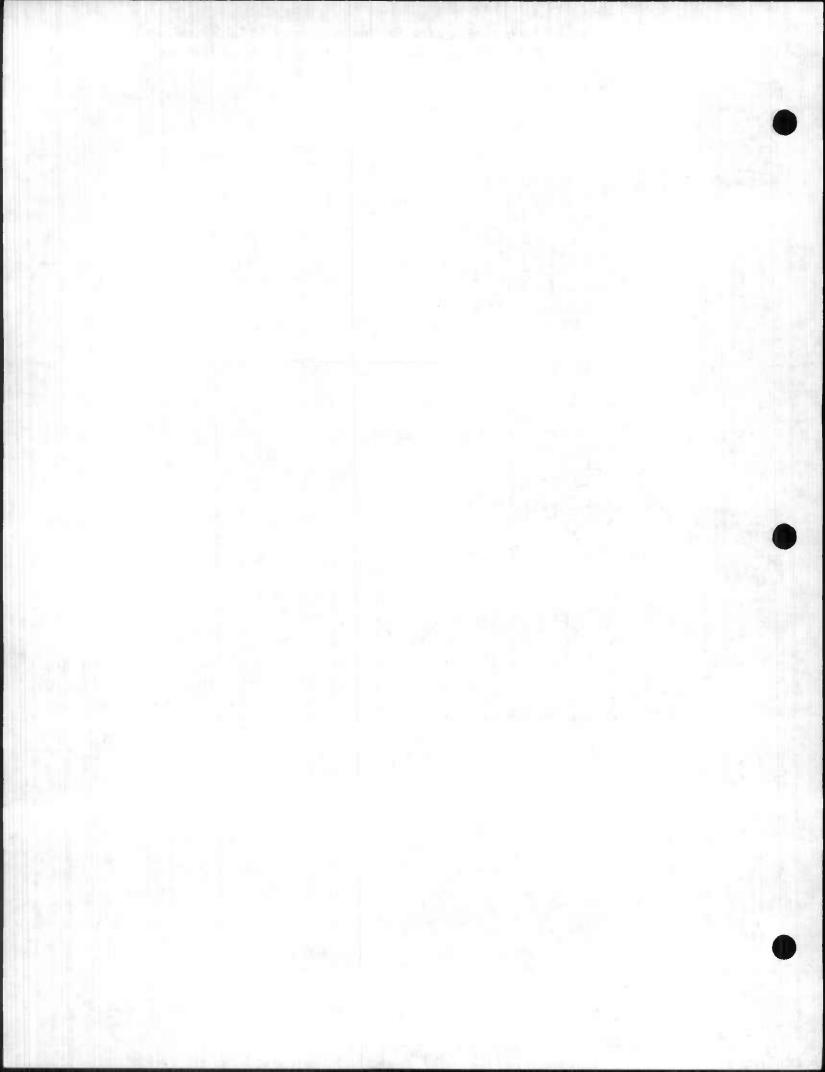
State of Maryland / Department of Health and Mental Hygiene 0 1381

			Ce	rtificate of	Death	Reg	. No.		01
	1. Decedent's Name (First, Middle, Las	st)			2	. Date of Deeth Month	Day	Year 3. Tir	ne of Deeth
cian dical	HAROLD	EARL N	ACCARTY	SR.		JANUARY	,		:00 A
iner	4a Facility Name (If not institution, give	e street and number)			4b. City, Town, or Loca	tion of Death	4c. County	of Death	
, l	Frederick Memor 5. Social Security Number 6. So	ex 7. Age (In yrs	a1 . last birthday)	If Under 1 Year Months Days		k Dete of Birth (Month, Day, Y	Frede	9. Birthplace (S Country)	tate or For
	213-10-8324 Usual Residence of Decedent	X M 2□ F	80 Yrs.	Working Days		lovember 2	1,1919	MD	
	10a. State 10b. County	10c. C	ity, Town or Le	ocation				10d. Insi	de City Lin
ğ	MD Washingt	on Ha	ncock	K 10		The state of	200 2	10	Yes 2
irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of W	Vhat Country?	11.7
a D	13808 Exline Road			21750			USA		
Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Speciloan, Mexican, Puerto Ric	y Yes or No- can, etc.)		e - American India k, White, etc.	an,
þ	1 ☐ Never Merried 2 M Merried 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ 1941 — If Yes, Give 1941 — Year or Dates 1936 —	45	1□ Yes 2No	Specify:		Specify:		
ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usuel Occu	pation during most of working	16	b. Kind of Bu	siness/Industry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)				
Co	11		Polic	e Office	T-100		-	Governme	ent
Be	17. Father's Neme (First, Middle, Last)				18. Mother's Name (i			(8)	
2	Earl N. McCarty				Margaret			0 7. 0. 4.1	
	19e. Informent's Neme/Reletionship (7				ot and Number or Rural F			State, Zip Gode)	
	Christopher J.McCa 20a. Method of Disposition	-		o EXIIIe	Road Hanco			City or Town, Ste	ite
	1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	cametery, cre	matory or other pla	ace)				
	4 □ Donation 5 □ Other (Specify	· I Dis		rg Crema	tory 1/1	3/2000 S	mithsb	urg, MD	
	21. Signature of Funeral Service Licen	\$ 66		2. Name and Addr	eral Home,	P.A.			
	Kicken	Morie	/ 1	41 W. Mai	n St. Hancoc	k MD 21	750-03	68	
	23a. Part1. Enter the disease, or conve shock, or heart failure. List only	one cause on each line.	9th. Do not en	ter the mode of dy	ing, such as cardiac or i	respiratory arrest	t,	Interve	ximate al Between and Deat
	Immediate Cause (Final	0				STOLENS TO	7757		
	disease or condition resulting in death)	. Sepsis						10	lay
0	BEAUTIFUL THE	0	(or as a conse	quenca of):			1000		10.
Examiner	Sequentially list conditions	b. Uspiration	(or as a conse	eumon i	14			1 6	rug
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	· Swallow		1 0	4			I CON ex	- Ma
edicai	Ceuse (Disease or Injury that initiated events resulting in death) Last	C. Due to	or as conse		non			170	yu v c
	resulting in death) cast	a alzheim	eris	denent	49			ye	ars
Physician/M	Part It. Other eignificant conditions co	ontributing to death but not re	sulting in the	underlying cause g	iven in Part t.	23b. Dld toba	ecco uee cor	ntribute to the ca	uee of d
hy			-	0 1		1 Yee	-	3 Probably	
by l	oush oin rest	na bleed	3,	etrial					
Completed by	- Gastroinksti Abrillation		- 61			24a. Was an performe		24b. Were auto available	prior to
pie	- FLOT ITI WITH							completion of death?	n of caus
Con						1 ☐ Yes	2.0 No	1 □ Yes	2□ No
Be	25. Was case referred to medicat				26. Place of Death (Check only one)			
2	1 Yes 2 No		☐ ER/Outpatie	nt 3LI DOA	ther: 4 Nursing Home				
0.0	27. Manner of Deeth 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W		d. Describe how	injury occurr	Det	
O	2 Accident investigation		hama 4		Yes 2 No	Location (Cr-	at and Nomb	er or Rural Route	Number
ication	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	nome, tem, st cify)	reet, factory, office	20	City or Town,		o, or moral mode	, reambel,
rtification	E - Modiowitt	building, etc. (Spec	**					anner se stated	
Ical Certification:	3 Suicide 4 Homicide Could not be determined	building, etc. (Special Special Specia							use(s)
edical	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phyone)	building, etc. (Spec		nvestigetion, in my	opinion, death occurred	at the time, det	e and place, a	and due to the ca	
Medical Certification	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, efc. (Special Special Specia		29c. Licer	opinion, death occurred	at the time, det	e and place, a		71160
edical	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier Rathur W	building, etc. (Specific Specific Speci	ation and/or in	29c. Licer	opinion, death occurred	at the time, det	e and place, a	and due to the ca	
edical	3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exam 29b. Signature and title of certifier Rathun W 30. Name and address of person who of	building, etc. (Specific Specific Speci	em 23a) (Type	29c. Licer	opinion, death occurred	at the time, dete	e and place, a	and due to the ca	
edical	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier Rathur W	building, etc. (Specific Specific Speci	em 23a) (Type	29c. Licer	opinion, death occurred	at the time, dete	e and place, a	and due to the ca	

& DHA

DHMH 16 Rev 6/95

MIMM A A AAAA



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month Physician 19 Mary Dove McCormick January 2000 8:10 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Place 830 W. 40th Street Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs.

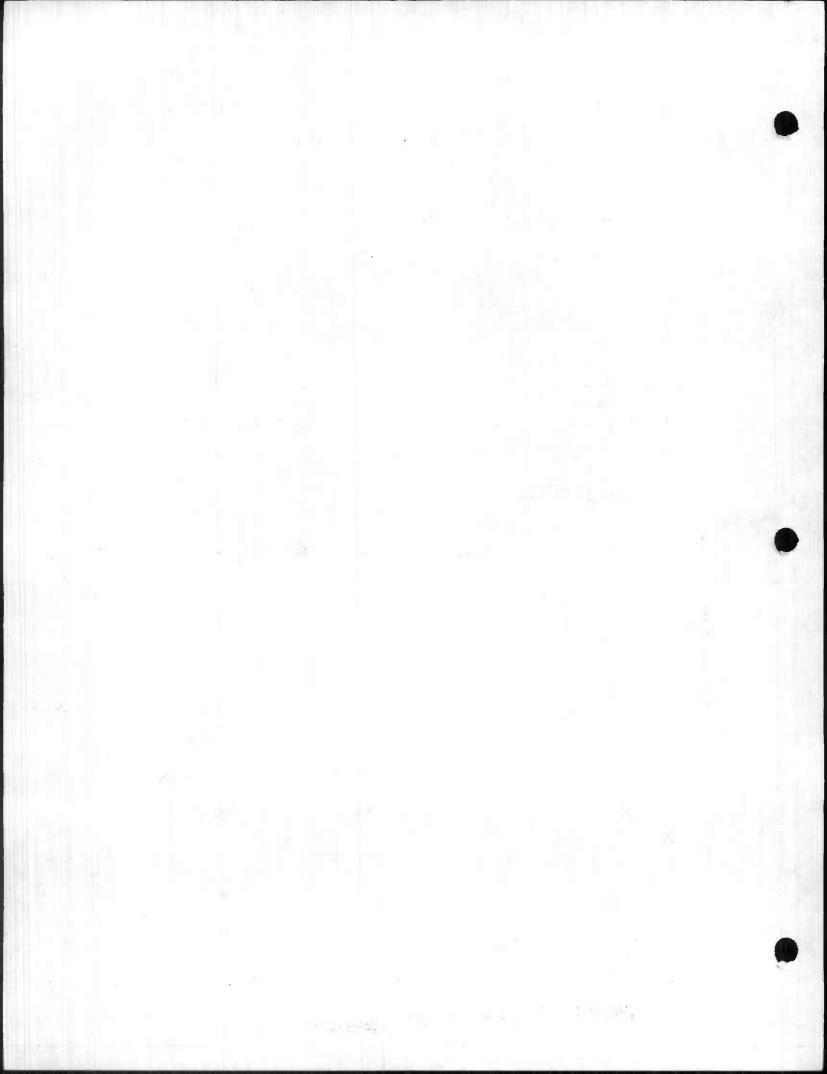
Months Days Hours Min. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 XF 220-44-1744 101 Director 1898 June 16. Maryland Usuai Rasidenca of Dacedani 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits Maryland N/A 1 X Yes 2 □ No Baltimore Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 830 W. 40th Street 21211 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No if Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien Black, Whita, atc. 11 Marital Status then "setural", or item the Medical Examiner Pages 1 and 2 should be filed within 72 hours after of health and Mentals Hygiene.

wit: If New 37 is marked other than "helpmal", or the sty or other traument, the Medical Examination ary or other traument overs, the Medical Examination. 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Herbert Urban Dove Georgia Howard 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Hugh P. McCormick 606 Brightwood Club Drive (Son) Lutherville, MD 21093 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Crametion 3 ☐ Removel from State Department of Important: If any injury or ance. 4 □ Donation 5 □ Othar (Specify) 1/22/00 Druid Ridge Cemetery Pikesville, Maryland 21. Signature of Funerel Sarvice Licensee 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Leven! Etitle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between **Physician** Abdominal Aortic Aneurysm /Medical Immediata Causa (Finat diseasa or condition rasulting in death) Examiner the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Entar Undarfying Cause (Disease or injury that initiated evants rasulting In death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 88 for use Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hyperlens Division of Vital Records, ģ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, 25. Was case refarred to medicat examinar? Be 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Medical Certification: To After this 27. Mannar of Death
1 Natural
2 Accident 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending Investigation 1 | Yas 2 | No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signatura and titla of contilled 29c. License number 29d. Dete signed (Month, Day, Year) ,20,2000 D20650 30. Nama end addrass of person who completed causa of death (Item 23a) (Type, Print) David D. Collins, M.D. 6701 N. Charles Street Suite 4101 Towson, Maryland 21204 32. Pagistrar's Signature 31. Data filed (Month, Day, Year) State JAN 2 1 2000

DHMH 16 Rev 6/95

Registrar

sports



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEMS: #10C, d,e,f G779 1-21-2000 WR. Reg. No. 3. Time of Death 1. Decedant's Nema (First, Middla, Last) 2 Date of Death Month **Physician** 12:20 AM C ACHANNA 2000 NAECKER /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner EASTON If Undar 24 Hrs. TALBOT HOSPICE FOUNDATION IALBOT If Under 1 Yeer Birthplece (State or Foreign Country) 5. Sociel Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 KF Hours 5/1/78 230 17 5427 Usual Residence of Decedent 21 Yrs Director with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be incuffed at ROVAL OAKS THEY'S 2 NO Director MD IALBOT ASTON 10e. Street end Number 25911 GOOSE NECK ROAD 10g. Citizen of What Country? 10f. Zip Code 21662 21601 USA Funeral STREET 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Merital Status 2 should be filed within 72 hours after n and Mental Hygiene. 1 ☐ Yas 2 No If Yes, Give Year or Datas: 1 Navar Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) Elementery/Secondery (0-12) College (1-4or 5+) HARDWARE CLEEK 12 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be MARCIA JAN MOTE HAMOND WESLEY NAECKER 10 19a, Informent's Neme/Rejetionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 is m eny injury or other traum ARMOND WESLEY NAECKER FATHER 18 BREWER ANNAPOUS, MD 21401 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/2000 CATONSVILLE MD HD CREMATION SOCIETY 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility dward A Cremation Society of MD, Inc. Edward A. Gregorchik 299 Frederick Road Baltimore, MD 21228

23a. Perl1. Enter the diseasa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each lina.

Approximate Intervel Between Approximete Intervel Between Onsel end Death **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in deeth) ARTE THromBOSIS 2 WEEKS **Examiner** Due to (or es a consequence of) SYSTEMIC LUPUS Examir Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest P S Due to (or as e consequence of) physician the burla Box 68760 Physician/Medical Dua to (or as a consequenca of): # 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 96 3 Probably 4 Unknown signed by 1 | Yes 2 | No þ Division of Vital Records. 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? certificate has 1 ☐ Yas 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yas 2 No 2 ER/Outpatient 3 DOA Hospice 1 Inpatient 報 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Olivector: 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mospital 24 hours a 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as steted. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) end manner stated. 2 To the 29b. Signeture end title of cartified 29c. License number 29d. Dete signed (Month, Dey, Year) MA DO0 5057

Registrar

State

JAN 2 1 2000

who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

EASM, MA

30. Name and address

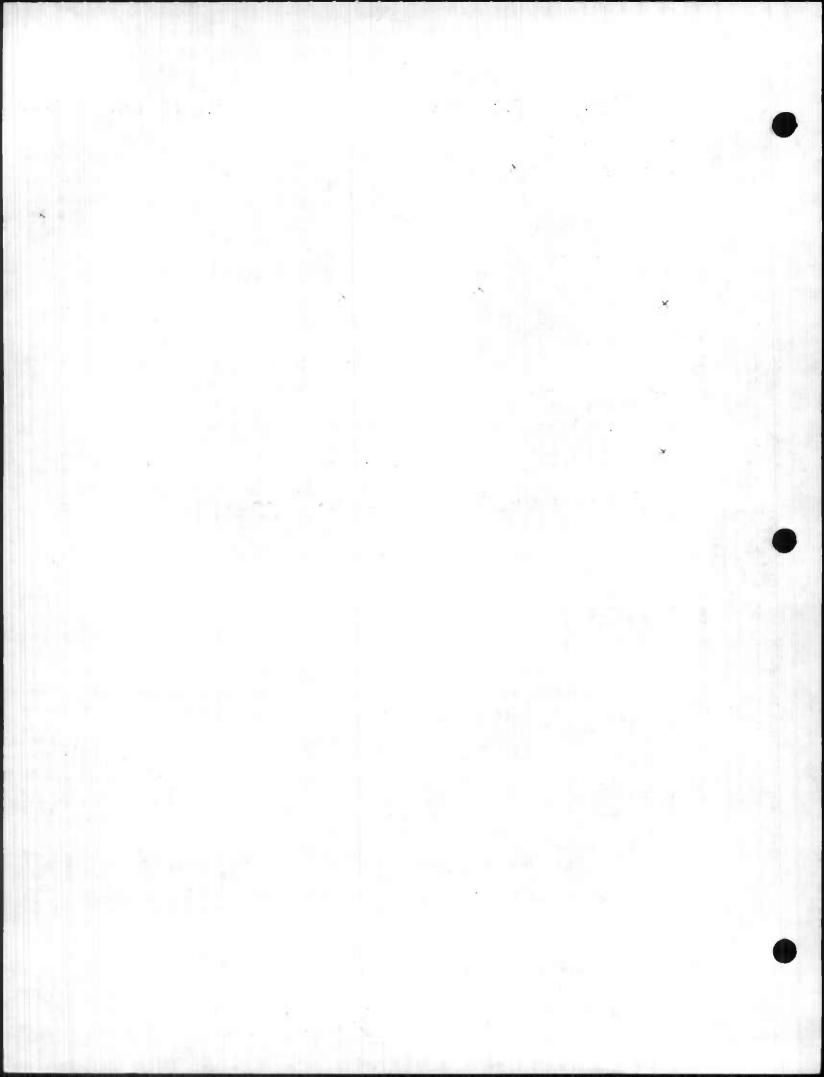
31. Dete filed (Month, Day, Year)

Pr20200

Physician	1. Decedant's Na	ma (First, Middle, L	ast)		Certificate of	Deam	2. Date of Death			e of Death
/Medical		Joan	Neu	pde			Ja nuary	18 2	UUU !	.00pm
Examiner			ive street and number)	q		4b. City, Town, or Los		4c. County of	imore	,
	5. Social Security	nt Nursin		(In yrs. last birth	rday) If Under 1 Year	Eastpoin	8. Date of Birth			te or Foreign
uneral irector	212-36-3	3680	A CLAR OFFI		rs. Months Days	Hours Min.	(Month, Day, Ye	38	9. Birthplace (Sta Country)	MD
adat of	10e. Stete	10b. County		10c. City, Town	or Location	1070			10d. Insid	e City Limits
ner must be notified Funeral Director	Md	Baltim	ore	Dund	alk				10	res 2 No
al Director	10e. Sfreet and N 2721 Cr	_{umber} eston Roa	d		10f. Zip Code 212	222	10g.	Citizen of Wh		
by Funeral		rried 2 Merried	12. Was Decedent I Armed Forces? 1 Tyes 2 21 If Yes, Giva Year or Detes:	ew.	13. Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indias White, etc.	
Completed	(Spe	15. Decedent's E ecify only highest gr condery (0-12)	Education rada completed) College (1-4or 5	+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of working	168	o. Kind of Busi		
	17 Father's Neme	(First, Middle, Las	t)	H	omemaker	18. Mother's Neme	(First Middle Mai	Own Ho		
o Be		John Eck				Bella L				
F		Name/Relationship		19b.	Meiling Address (Street				tate, Zip Code)	
	Kelly M	cMillion/	daughter	27	21 Creston	Road, Dun	dalk, Md.	21222		
		Cremetion 3	Removel from Stete	cemetery	Disposition (Nama of , cremetory or other ple		10.0		ity or Town, Stat	в
Ē		5 Other (Speciment) Service Lice		Parkw	ood Cemete:	-	1 22 Ba	altimor	e, Md.	
8	1 Trale	Solle	Darel			shton-Matt				
	23e. Pert1. Enter shock, or he	the disease, or core	nplications that caused	the death. Do no	ot enter the mode of dyi	ing, such es cardiac o	respiratory arrest	, PIU.	Approxi	Between
n al er	Immediate Cause disease or condit resulting in death	ion		Due to (or as a co	MSCh(ar	Diseas	ie		I I	nd Death
I Examiner	Sequentially list of if any, leeding to causa. Enter Und Ceuse (Disease of	onditions, immediate lertying	b	Due to (or as e co	onsequence of):				4 5 0 0 0	
n/Medical	thet initiated even rasulting in death	fs	d	Dua to (or es a co	nsequence of):					
sicla	Part II. Other sign	ificant conditions	contributing to death bu	t not resulting in	the underlying cause gi	ven in Pert I.	23b. Did toba	cco use conti	ribute to the cau	se of death?
by Physician/Me	0	oronary	Artery	Dise			1 Yes	2 No 3	3 Probably	Unknown
						70	24a. Wes en a		24b. Were autopavailable prompletion of death?	ior to
0							1 🗆 Yes	2 No	1 🗆 Yes	2 No
omo	0.000	erred to medical				26. Place of Deeth	(Check only one)			
omo		niod to modical			Ot	her: A Nursing Hor	ne 5 Residenc	e 6 DOther	(Specifu)	
To Be Comp	axaminer?	3No	Hospitel: 1 🗆 Inpatie	1	patient 3LJ DOA					
To Be	axaminer? 1 Yes 2 27. Menner of Der 1 Neturel 2 Accident 3 Suicide	ath 5 ☐ Pending investigetic 6 ☐ Could not	28a. Dete of Injur (Month, De)	y 28b. Ti	me of 28c. Inju	ry et 2 ork?] Yes 2 [] No	28d. Describe how 28f. Location (Stree	injury occurred	d	Number,
To Be	axaminer? 1 Ves 2 27. Menner of Det 1 Neturel 2 Accident	ath 5 ☐ Pending investigetic 6 ☐ Could not	28a. Dete of Injur (Month, De)	y 28b. Ti	me of Unit Wo	ry et 2 ork?] Yes 2 [] No	28d. Describe how	injury occurred	d	Number,
To Be Comp	axaminer? 1 Yes 2 27. Menner of Der 1 Neturel 2 Accident 3 Suicide	sth 5 Pending investigetic 6 Could not determined	28a. Dete of Injur (Month, De) 28e. Plece of Injur building, etc	y Year) 28b. Ti Inj Inj Year) 28b. Ti Inj Inj Year) 28b. Ti Inj Inj Year) 18b. Ti Inj Inj Year) 18b. Ti Inj Inj Year) 18b. Ti Inj	me of Unit Wo	ry et ark?] Yes 2 □ No 2 ime, date and place, e	28f. Location (Stree City or Town, S	nt and Number	or Rural Route	
To Be	axaminer? 1 Yes 2 2 27. Menner of Del 1 Meturel 2 Accident 3 Suicide 4 Homicide 29e. Certifler (Check only)	5 Pending investigative of Could not determined. 1 Certifying P	28a. Dete of Injur (Month, Detection of the Detection of	y Year) 28b. Ti Inj Inj Year) 28b. Ti Inj Inj Year) 28b. Ti Inj Inj Year) 18b. Ti Inj Inj Year) 18b. Ti Inj Inj Year) 18b. Ti Inj	me of ury M 28c. Injury M 1 1 28c. Injury M 1 1 28c. Injury M 1 1 28c. Injury M 1 28c. Injury	ime, date and place, e	28d. Describe how 28f. Location (Stree City or Town, S and due to the caus do at the time, date	injury occurred and Number (tete) e(s) and mani and place, an	or Rural Route	so(s)
To Be Comp	axaminer? 1 Yes 2 2 27. Menner of Det 1 Meturel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one)	ath 5 Pending investigetic 6 Could not determined 1 Certifying P 2 Medicat Exe	28a. Dete of Injur (Month, De) 28e. Plece of Injur building, etc 28e. To the best of miner: On the basis of and manner ste	y Year) 28b. Ti In In In I	me of uny M 28c. Injury M 1C m, street, fectory, office death occurred at the troor investigation, in my case. D 4 3	ime, date and place, a opinion, deeth occurre	28f. Location (Stree City or Town, S and due to the caused at the time, date	injury occurred in injury occurred inj	or Rural Route on Rural Rur	se(s)

DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

-	-	Certificate of Death	Reg. No.
	Showlein	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physician /Medical	TIRTING MILETS. TIRTINGES. COUNTY	JAN 18 2000 12:50A
	Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, o	or Location of Death 4c. County of Death
			DMITHUL
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	n. (Month, Day, Year), Country)
т.	Bircotor	Usual Residence of Decedent	Sept. 10,1963 Pennsylvaria
	nytan show	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	or 28a-f s be notified Director	Warylow PANE ARUNDEL ANNAPOLIS	1. Yes 2□ No
	Direct Direct	10e. Stréet and Number 159 OBERRY QURT 101. Zip Code 21401	10g. Citizen of What Country?
	s 23s must eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14. Race - American Indian,
-	har death v r Herre 23s siner.must Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	ento Rican, etc.) Black, White, etc.
5-0020	Eran Eran Dy	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify: Block
9	ed within 72 ho tygiens. Wer then "meturn it, the Medical. Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	16b. Kind of Business/Industry
.B.	Mple Man	(Specify only highest grade completed) (Give kind of work done during most of white black iffe. DO NOT use retired) College (1-4or 5+) October 17845 Teachers 18656	SONICIA FIBER GIA
a.n	Co Region	17. Father's Name (First, Middle, Last)	rame (First, Middle, Maiden Surneme)
50	Mental H Mental H sriked off affic ever To Be		ICES LEAN THORNAN
2: ary	M bu M bu mark		Rural Route Number, City or Town, Stele, Zip Code)
7 2	ally a	DARIUS G. Odum HUSBOND 159 OBERRY COUR	+ Annapolis, nd 21401
2000 Imore	of Te	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemelery, cremelory or other place)	Date 20c. Location - City or Town, State
2000	Pag ment ant: I	4 Donation 5 Other (Specify) Green World Cinestery	1 /21/200 Bullvaron, Marylone
8,	my in the part		HATHAN- IMPRILATIONAL HONE
	AM3 · ·	Spray Harris BOLGILLOR Rd	
ar		23a. Part*. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart tailure. List only one cause on each line.	ac or respiratory arrest, Approximate triterval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	Oriset and Death
Ja	Examiner	disease or condition resulting in death) a ACQUIRED IMMUNE DEFICIENCY SYNDROM	E
E	ě	Due to (or as a consequence of):	
MUdo	icate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions, Due to (or as a consequence of):	
	be exempled by exemple burdal-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
DAWN 68760	g physician as the burla fedical E	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
_	- O 0		
Вох	v requires that the death cert been signed by the attendin should be deteched for use leted by Physician/W	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco use contribute to the cause of death?
P.O.	by the scheen	Part II. Other alignmeant conditions continuiting to death but not resulting in the underlying cause given in Part I.	1 Yaa 2 No 3 Probably 4 Voluntown
	be del		-
Division of Vital Records,	The law requires that state has been signed by page 2 should be determined.		24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to
00	The law require cate has been single 2 should I Completed		completion of cause of death?
<u> </u>			1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
Vita	entific entification	25. Wes case referred to medical examiner?	eath (Check only one)
of		1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing	Home 5 ☐ Residence 6 KOther (Specify) HOSPICE 28d. Describe how injury occurred
on	ding h. After fune	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 2 Accident Investigation M 1 Yes 2 No	250. Describe now injury occurred
S	tal or Attending P rs after death. at Director: After t led in by the funera Certification:	2 Accident investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
á	or after	4 ☐ Homicide building, etc. (Specify)	City or Town, State)
	hourn hourn amera ty fills	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death oc	
	the Hospit in 24 hours the Funer pletaly fill	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death oc and manner steted.	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral Medical Certification:		29d. Date signed (Month, Day, Year)
		D43725	1/18/00-
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	State	DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIU 31. Date filed (Month, Day, Year) 32. Registrar's Signature	M, MD 21093
	State Registrar	JAN 2 1 2000 Benera G	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** 9 15 AM 18,2000 anuary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Apt hesco more. If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 250-40-6197 10 M 24F 71 Yrs. Director 1928 SC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Ves 2 □ No Director MD N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If ten 27 is marked other than any Injury or other traument. 1315 Chesco Ave Apt 324 21237 238 U.S.A Funeral 14. Raca - Amarican Indian, 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. I ☐ Yas 2⅓ No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 Yes XXNo Specify: Specify: Black þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Garment. Garment Worker 12th N/A 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Edd Brockinton Emma Pugh 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara McMullen 1315 Chesco Ave Apt 324 Balto, Md 21237 20b. Place of Disposition (Name of cematery, crematory or other place)
Maryland National Cem1-22-00 Laurel, Md 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Betts Funeral Home 1129 N. Caroline St Balto, Md 21213 us 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one ceuse on each line. Interval Between Onset and Death Physician Immediata Cause (Final disease or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Be Completed 2 should certificate has page 2000 1 Yes 1 Yes or Attending Physician: filled in by the funeral director, 25. Was cese referred to medical 26. Piece of Deeth (Check only one) axaminar? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA edical Certification: To After this 27. Menner of Deat 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Division 1 Natural 5 Panding investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital the Funeral 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) To the

State Registrar

10

2000 JAN 21

32. Registrar's Signatura Sense

W

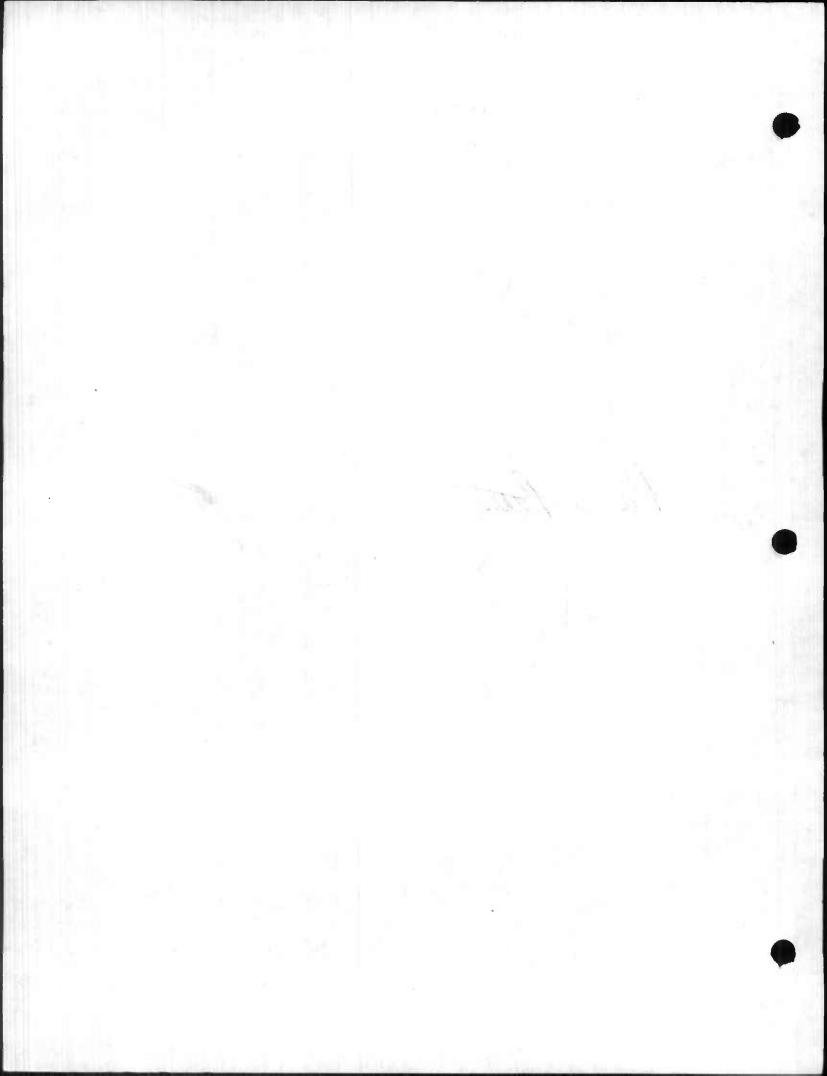
29c. Licensa number

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

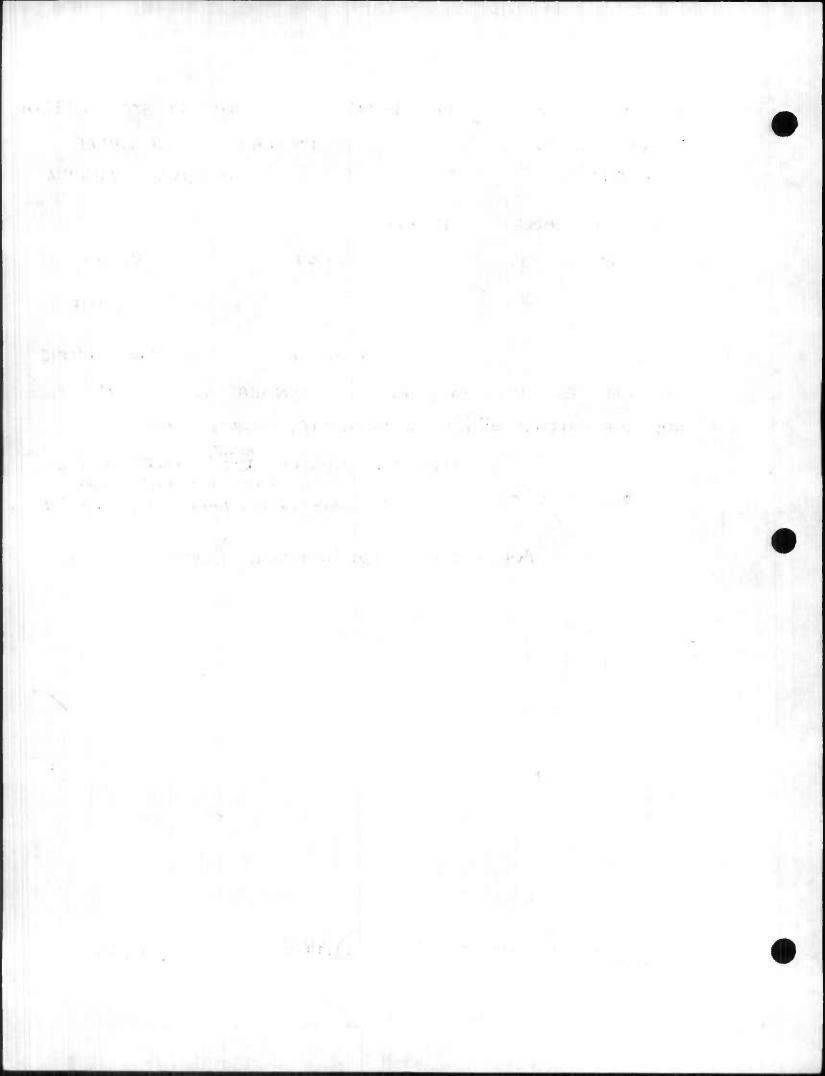
29b. Signature and title of certif

death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 0 1387

					Certifi	cate of	Death		R	eg. No.		
	1. Decedent's Neme (First, Middle, La:	st)						Dete of Deet Month	h Dev	Year	3. Time of Death
Physician	VIRGINI	Α	PAIGE	PA	MERS	SAO			JAN		200	12:45
/Medical Examiner	4e Facility Name (If n						4b. City, Town	-		4c. County		.0. 10
LAdiiiiiei	2 FRANCE		-				BDCC	~ ~ ~ .	_	COAL	TIME	105
	5. Social Security Num			ge (In yrs. las	t hirthday) If	Under 1 Yeer	If Under 2	AHrs. 8	Dete of Birth		TIM(
uneral irector	The same of the sa		□M 2ØF	78	Yrs. Mo	onths Deys	Hours		Dete of Birth (Month, Dey,		Coun	ece (State or Forei
rector	219-16-851 Usuel Residence of D			.0					EPT 10	11741	VI	RGINIA
E as		0b. County		10c. City,	Town or Location	n					10	d. Inside City Limi
adat adat	110	DA 1		-	0000	_						1 Yes 2 7
be notified Director	MD	BALTI	MORE	K	DSEDAI	Of. Zip Code			1.4	Og. Citizen of V	Prot Course	
5 8 5	10e. Street and Numb	er				UI. ZIP COUB						
ral mar	2 FERI	NSELL				219				-	J.S.	
iner must	11. Meritel Stetus		12. Wes Deceder Armed Forces	t Ever in U,S.	13. Was	Decedent of h	dispenic Origi en, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		a - America k, White, o	
			1 Yes 2 If Yes, Give	No		Yes 2 No	Specify:			Specify		
Ere I		Divorced	Yeer or Detes	:				1.0		Openin	Wt	HITE
Ar the Medical	(Specify	5. Decedent's Ed	ducation		16e. Decedent'	s Usuel Occup	pation	of working		16b. Kind of Bu	siness/Ind	ustry
e Me	Elementery/Second		College (1-4o	5+)	life. DO I	of work done IOT use retire	d)	or working				
that to	12	The last			5	VSSAU	ISOR			WESTER	NE	LECTRIC
B 8 0		rst, Middle, Last)					18. Mother	's Neme (F	irst, Middle, I	Aaiden Sumem	Θ)	
kad licev		F.	WHITE	LER,	SP		CJA	THIA	A	BUR	TOA	
in it	19e. Informent's Nem		Tyne Print)		19b. Meiling A	ddress (Street						
T'is			SIS	SISTE								
68	CATTERINE 20a. Method of Dispos		FUER, IN	LAW Pier	920 M		DIZ.		Dete	20c. Location -		
世帯			Removel from Stet	0.00	netery, cremeto	ry or other ple	ce)	JAA	J. 18.			
# A	4 ☐ Donetion 5	Other (Specif)	y)	PAR	KWOO			3.0	000	PARK	nue	MO.
858	21. Signeture of Fune	rel Service Licen	1500		22. Na	me end Addre	ess of Fecility	EVA	VS FU	VERAL	CH	APEL
B 8 8	tan	vi sil	7		COL	an LLA	AFOR					
	23e. Petri. Enter the	disease, dr.com	plications that cause	ed the deeth.	Do not enter th	e mode of dyi	ng, such es c	ardiac or re	spiretory err	est,	, row	Approximate
sician	skock, or heart f	ellure. List only	one sause on each	line.								Intervel Between Onset end Death
ledical	Immediete Ceuse (Fir	nel	Anter	1.	1.	C 1:	411.6-	(Y	-		. 1
mine	diseese or condition resulting in deeth)		" unter	o scre	whe	Cardi	ovacc	alav	Dize	ase	-	years
E E				Due to (or e	s e consequen	ca of):					1	
in and hal-transit Examiner			b								1	
and I-trar	Sequentially list cond	tions,		Due to (or e	s e consequen	ca of):					1	
ician and bunal-transit	cause. Enter Underly	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequenca of): Due to (or es e consequenca of):										
physician is the buna edical E	that initiated events resulting in death) Les	st	0.	Due to (or e	s e consequenc	a of):						
Se se												
I for use			d	-								
d fo	Pert II. Other significe	nt conditions c	ontributing to death	but not resulti	ng in the under	lving cause of	ven in Part I.		23b. Dld to	bacco uee co	ntribute to	the cause of deat
ache ache	The state of the s					, g casse gi				• 2□ No	3□ Prot	
De de la company									, , ,	22.140	7_1100	,
sate has been signed by the attend page 2 should be detached for us Completed by Physician/									24a. Wes e	n eutopsv		re autopsy finding
shou									perfor	med?	COL	ilable prior to npietion of cause
irector, page 2 sirector, page 2 s										,	of	death?
pag Con									1 🗆 Y	s 2 No	10	Yes 22 No
director,	25 Was case referred	to medical					26. Plece	of Deeth (C	heck only or	e)		
			Hospitel: 1 ☐ Inpa	tient 2 El	NOutpetient 3	DOA OI	her: 4 Nurs	sing Home	5 Reside	enca 6 DOth	er (Specif)
2			28e. Dete of In (Month, D		8b. Time of	28c. Inju	ry et	28d	l. Describe h	ow injury occur	red	
funer	1 ☑Neturel 2 ☐ Accident	5 Pending investigation		oy rear)	Injury		rk≀]Yes 2 □ N	lo				
al Director: After t led in by the funers Certification:	3 Suicide	6 Could not be	e 28e. Piece of I	njury - At hom	e, ferm, street,	fectory, office		28f.			er or Rure	l Route Number,
in b	4 Homicide	determined	building,	c. (Specify)	.,,	, 511104			City or Town			
E O			1.1		oden de d			1	Latina to 25			atad
pletely fill edical	29e. Certifier 1		ysician: To the bes niner: On the basis	of examinetio								
- 5 D	(Check only 2	_ Medical Exam	and menner s			-						
E 0			and monitor							0.1.0		
To the		a of certifier	and monitor a			29e Licen	se number		2	9d. Dete signe		
Comp			and monitor a	5		29e Licen	se number		2	9d. Dete signe	(Month,	
To the	29b. Signethre and thi	e of certifier		death (Item 2	(3a) (Type Prin	00	9423			1/20	0	
To do w		e of certifier		deeth (Item 2	3a) (Type, Prin	00	9423	e Bi		1/20	0	
90	29b. Signeture and tell 30. Name and address	e of certifier s of person who	completed cause of	R 5	6011	00	9423	r Be		9d. Dete signe 1/20	0	
To the Funeral Director: A completely filled in by the funeral state of the funeral by the funeral state of the fu	29b. Signethre and thi	e of certifier s of person who	completed cause of	deeth (Item 2	6011	00	9423	r Be		1/20	0	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month 8:15 pm **Physician** Junuary Janice Preston /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner Bultimore N/A Sinai Hospita If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) **Funeral** Days Hours 1 M 2 F Yrs. 09 1925 336-22-4734 74 North Dakota Director Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. fnsida City Limits the Maryla "netural", or flerns 23a or 28a-f show the Medical Examiner must be notified at 1 X Yas 2 No Director Md Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Presson 20878 USA 9701 FieldsRoad, Apt 1605 Funeral Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar In U.S. Armed Forcas? 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yaa 2 🕱 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Saltimore, Maryland 21215-0020 À Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent'a Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) College Professor Chicago City College 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Pages 1 and 2 should be nent of Health and Mental is merked Ward Preston Celia Sanders 2 19a. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Important: If item 27 is any injury or other traun 9701 Fields Road, Apt 1605 Gathersburg, Md20878 Joseph W. Motz, husband 20b. Place of Disposition (Nema of cematary, cramatory or other place) Crem . 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 01/19/00 Laurel, Md Baltimore Washington 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licensee Sterling-Ashton-Schwab Funeral Home 736 Edmondson Ave Balto, Md 21228 for haert hailura. List only one cause on each line. Approximate Intarval Batwe Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting in death) /Medical tract intection Examiner Dua to (or as a consequence of) Examiner Cer an Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Diseasa or Injury and as the burial-tran The law requires that the death certificate be execu Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medicai that initiated evants rasulting in death) Last Dua to (or as a consequence of) 23h. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Be Completed has 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: after death. 25. Was casa ralarred to medical axaminar? 26. Placa of Death (Check only ona) Hospitet: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28d. Dascribe how Injury occurred 28c. Injury et Work? After 5 Pending Invastigation Natural 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) end mennar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number

DHMH 16 Rev 6/95

Janice

Motz,

State Registrar

31. Data fited (Month, Day, Year) 21

29b. Signatura and titla of certified

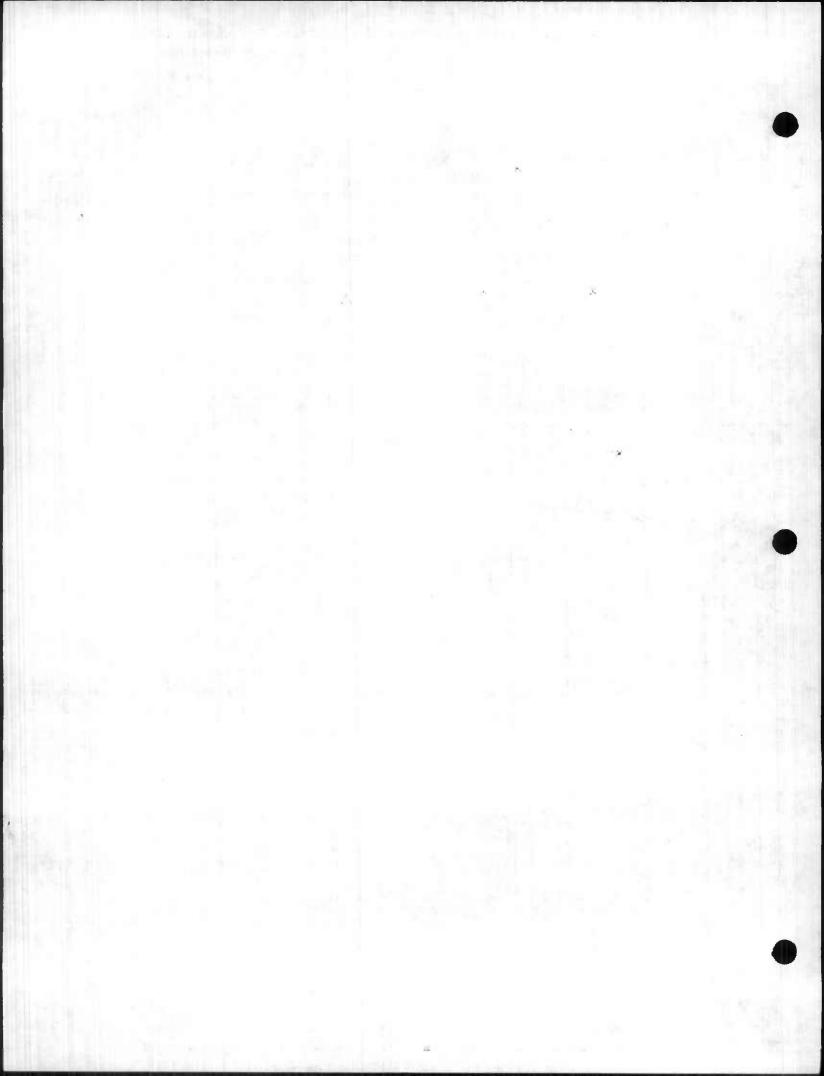
GINAI 32. Registrar's Signatura Ganera

30. Natina and addrass of person who complated cause of death (Item 23a) (Type, Print)

January

2000

בחחר ה ה חחת



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 00 43 AM 4a Facility Name (If not institution, give street and number) 2000 Jannery 4c. County of Deeth 4b. City, Town, or Location of Death RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Birthplece (State or Foreign Nauntry) 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 2□ F Months Deys Hours 86 Yrs. 050-011539 10n State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE N/A 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21215 6711 PARK HEIGHTS AVE. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Yes ZONo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2(No Specify: Specify: WHITE 3CXWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OPTICIAN OPTICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OTTENHEIMER PICK BERTHA PERRY 19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HIGHSTEPPER COURT #405 BALTIMORE, MD. 21208 BERTA GELLER/ DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ⚠ Removel from State SANCTUARY OF ABRAHAM & 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2000 PARAMUS, NEW JERSEY 21. Signature of Funeral Service Licens 22. Neme end Address of Fecility SOL LEVINSON & BROS. INC. 23a. Part1. Enter the disease, or complications the Leaused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 21208 Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) SUPSIS Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Was an autopsy performed? 2/3 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpalient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

The lew requires that the death certificate be axecuted Box 68760. Records, P.O. of Vital

for use as the buriel-transit signed by pege 2 has certificate or Attending Physician: After this Inneral Division To the Hospital or Attentions within 24 hours after death.
To the Funeral Director: After To the Funeral Directors After To the Funeral In by the fur

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

7 is marked other than "natural", or items 23s or traumstic avent, the Medical Examiner must be

Pages 1 and 2 should be flied within 72 hours efter of the fact of Health Hygiene. Interest if them 27 is marked other than Insturial; or flesting or other traumate avent, the lead of the fact of th

Department of important: If any injury or page

Physician /Medical

Examiner

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

Director

Funerai

þ

Completed

death with the Man/land

21215-0020

Maryland

Baitimore,

0

DHMH 16 Ray 6/95

State Registrar

HSine 31. Date filed (Month, Day, Year) JAN 2 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Ely West

32. Registrar's Signeture

29d. Dete signed (Month, Day, Year)

J000

Randallexon 12,

tix Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifie

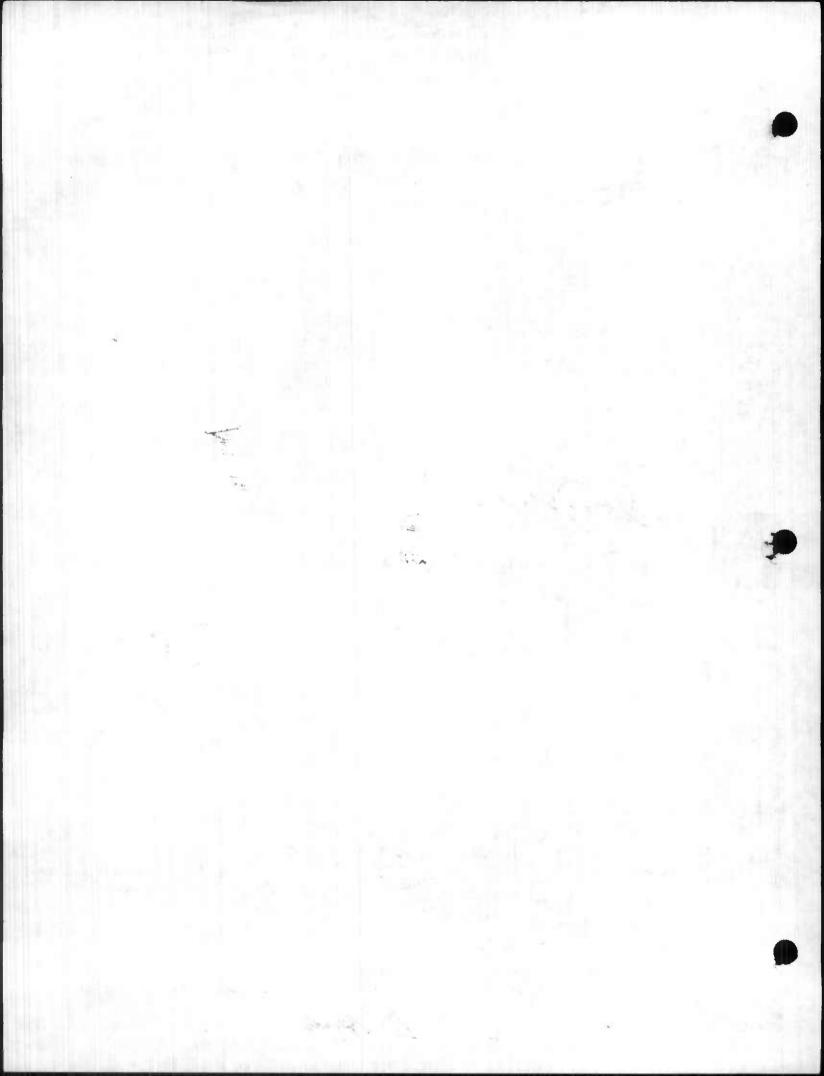


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joseph Ross Jr. January 2000 12:13 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral May 03, 1**X** M 2□ F Days Hours Min. Maryland 24 Yrs. 220-86-5655 Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at MD N/A 1 XYes 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 E. Fayette Street Funeral 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No It Yes, Give 14. Race - American Indien. Black, White, etc. or items Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk Supermarket 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fill trainent of Health and Mental Hismrt: If Itam 27 is marked out Joseph Ross Sr. Joyce Marie Crowell 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health as Important: If Itam 27 is Enportant: If Itam 27 is Enportant: Other tree once Joyce M. Crowell-Freeland (Mother) 3823 Lyndale Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burlat 2 Cremation 3 Removal from State Woodlawn Cemetery 1/21/2000 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licensee 5502 Winner Avenue Baltimore, Maryland 21215 complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, and only one cause on each line. Approximata Intarval Between Onset end Deeth Physician /Medical Immediate Causa (Final disease or condition resulting In death) GUNSHOT WOUND TO CHEST Examine Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai the Dua to (or es e consequença of) director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? hes 1 Yes 2□No Yes 2 No this certificate a) or Attending Physicien: The safer death.

In Director: After this certificate of in by the funeral director, pa 25. Was casa raferred to medicat 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1XXnpatient 2 ER/Outpatient 3 DOA 28b. Time of (28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1136 1 Natural 5 Pending 1 Tes SUBJECT SHOT 1/17/00 2 Accident investigation 3 ☐ Suicide 6 Could not be datermined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 900 Bulk N. CASTLE STATE 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicida STREET To the Hospital of within 24 hours a To the Funeral D BALTIMORE, MD 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and menner steted. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number O.C.M.E. January 18, 2000 30. Neme and address of person who completed causa of death (Item 23a) (Type, Print) JACK M. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar



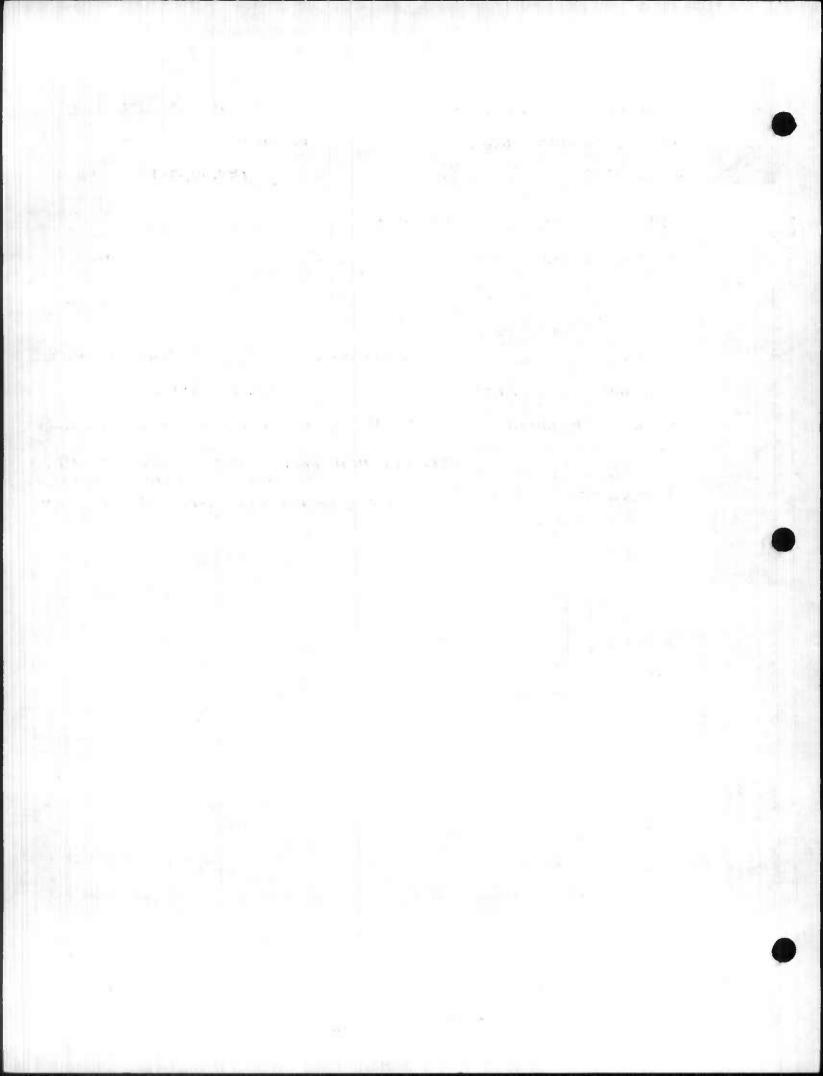
Decedent's Neme (First, Middle, Last)				Reg. 2. Date of Death		3. Time of Death	
an DOPOTHY E	miculinal D				Day Y	fear	
cal DOPOTH E 4a Facility Name (If not institution, give stre	PICHMOND eet and number)		4b. City, Town, or Lo	CAN leath	4c. County of		
4807 1/2 CALUMET	AVE.		BALTIND	DE	_	-	
5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	Months Day		8. Date of Birth (Month, Day, Ye	and 9	9. Birthplace (State or Foreign Country)	
217-22-3535 10M	20 ×	rs. Months Day		NOV. 10,1		MD.	
Usuel Residence of Decedent 10e, Stete 10b, County	400 Ch. Town						
	10c. City, Town	or Location				10d. Inside City Limits 1 ☑ Yes 2 ☑ No	
MD — 10e. Sfreet and Number	BALT	IMORE					
		10f. Zip Code		10g.	Citizen of Wh		
11. Maritel Stetus 12. 1 Never Married 2 Merried			1206			S - A. American Indian,	
11. Maritel Stetus 12.	Wes Decedent Ever in U,S. Armed Forces?	If Yes, specify Cu	f Hispanic Origin? (Spe Joan, Mexican, Puerto I	Rican, etc.)		White, etc.	
3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:	1 Yes 2 1	o Specify:		Specify:	1 4 4 1 4 CO	
		Decedent's Usual Occ	upation	160	o. Kind of Busin	WHITE ness/Industry	
(Specify only highest grade co	ompleted)	Give kind of work don life. DO NOT use reti	ne during most of working	19			
Elementery/Secondery (0-12)	College (1-4or 5+)	SELLETAR	27		OCIAL	SECURITY	
17. Father's Neme (First, Middle, Last)			18. Mother's Name				
WILLIAM J.	KANE		FREDIZI	CA HO	BUTZ	EL	
19e. Informant's Name/Reletionship (Type,		Mailing Address (Stre	et and Number or Rura				ĺ
WILLIAM S. PUCHME		071/2 (A	LUMET AV	E. BALT	IMORE	MD. 21206	
20a. Method of Disposition	20b. Plece of	Disposition (Name of crematory or other p		Date 200	Location - Ci	ity or Town, State	Ī
1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	over from Stete		. PARK		PARKY	ILE, MO.	
21. Signature of Funeral Service Licensee		22. Name and Add	Iress of Facility Eve	NS FUNT	ERAL	CHAPEL	
Jamery of							
23a. Park Enter the disease, cycombiotic slock, or heart failure. List only one	ons that caused the deeth. Do no	ot enter the mode of d	ying, such es cardiac o	r respiratory arrest,	-ville,	Approximete	
glock, or heart tailure. (List only one-c	euse on eech line.					Interval Between Onset and Death	
Immediate Cause (Final disease or condition	End Stag.	o Por	11/8/0	enco		2 manthe	
resulting In deeth) a	Due to for es a co		HI DIS	Cus-C		12 11011110	
Sequentially list conditions, if any, leading to immediate cause. Enter I ladertying.							
Sequentially list conditions.	Due to (or es a co	onsequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
Cause (Diseese or Injury thet initiated events resulting in death) Last	Due to (or es a co	nsequence of):				1	
d						1	
Part II. Other aignificant conditions contrib	uting to death but not resulting in	the underlying cause	given in Part I.	23b. Did toba	cco use contr	ibute to the cause of death?	
				1 Yes	2□ No 3	Probably 4 Unknown	
				24a. Was an a performed		24b. Were autopsy findings available prior to	
						completion of cause of death?	
				1 ☐ Yes	25 No	1 Yes 2 No	
25. Wes case referred to medical			26. Place of Death	(Check only one)			
examiner?	oitel: 1 inpatient 2 ER/Out	patient 3 DOA	Other: 4 Nursing Hor	ne 5 Residence	e 6 Other	(Specify)	ĺ
27. Manner of Death De	28a. Dete of Injury (Month, Day Year) 28b. Ti	me of uny 28c. In	jury el 2	8d. Describe how i	injury occurred		
2 Accident investigation			Yes 2 No				
27. Manner of Death 1. Shatural 2 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, ten building, etc. (Specify)	n, street, factory, offic	29	8f. Location (Stree City or Town, S		or Rural Route Number,	ĺ
	(-p)/						
29e. Certifier Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and	death occurred at the	time, date and place, a	nd due to the caus	e(s) and mann	ner as stated.	
	and manner steted.				paso, ath		101
29b. Signeture and title of certifier	-/	29c. Lice	nse number	-		Month, Day, Year)	
	loo, ms	29c. Lice	-0.1	-			
one)	Low Mb eled cause of death (Item 23a) (1	D	-0.1	5 JA			

State

DHMH 16 Rav 6/95

Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, Raver Raymond January 2000 8:20 PM 4a Facility Name (Myot institution, givel street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Battuliure

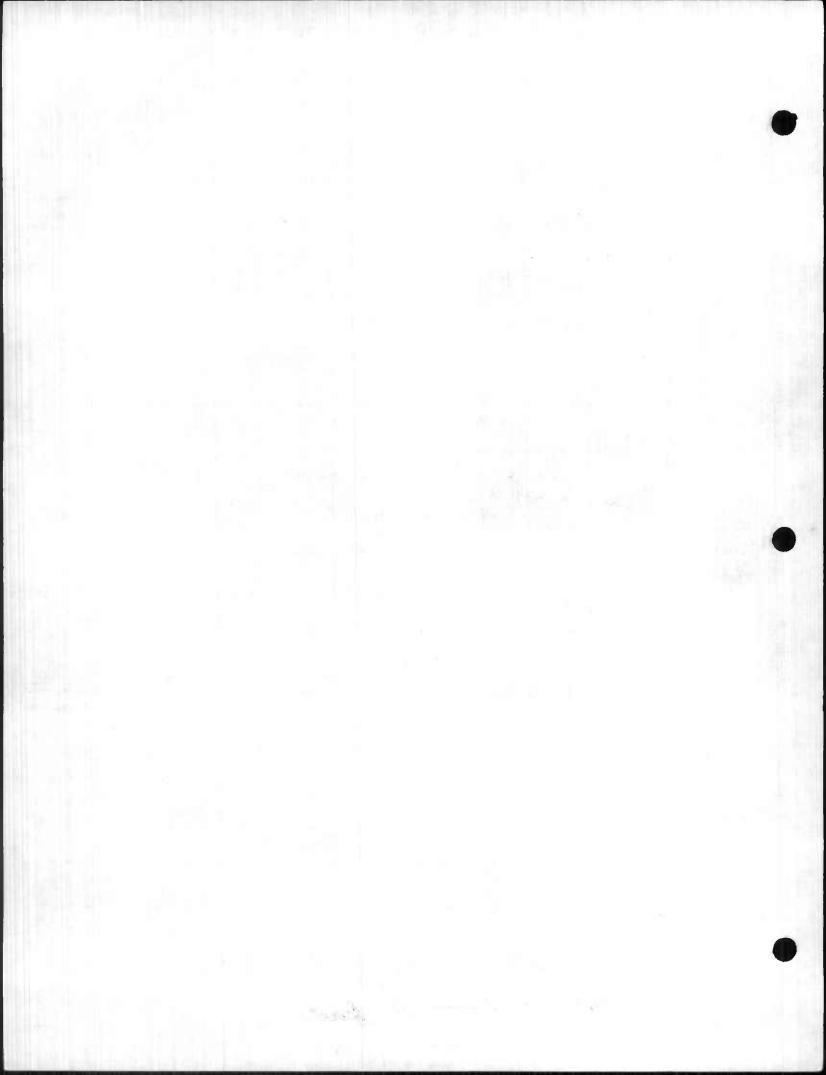
W Under 24 Hrs.
Hours Min.

| 8. Date of Birth (Month, Day, Year) | Nov. 30, 1928 Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F Months Days 71 Yrs. Maryland Director 220-22-6780 Usual Residence of Deceden 10a State 10h Counts 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 28a-f Parkville Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3304 Parktowne Road 21234 Norre 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried *natural', or I Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced il Hygiene. Other than *nature vent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil/Machine Operator Steel Company 8th Grade Coemit. Pages 1 and 2 should be Illia
Department of Health and Mental Hy
Important: If Ilem 27 is marked other
any injury or other traumatic event,
pages. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be George E. Raver Crescentia Schisler 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 Parktowne Road, Parkville, MD 21234 Mrs. Mildred R. Raver (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park ! 1/17/00 Baltimore. Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funerel Service Licensee a. Willem Buan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical CARDAIC ARRYTHMIAS Examiner Due to (or as a consequence of): Physician/Medical Examiner LERBERDVASCULAR DISEASE HYPERTENSION physician and s the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. BIABETES MELLITUS Due to (or es a consequence of) 98 HYPERLIPEDEM IA nse P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 | Yes 2 | No 3 | Probably 4 Munknown Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? 8 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division Affer or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital o within 24 hours aft To the Funeral Di 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cloreen Hashmi MO 00041635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 ROAD BALTO MO 21234 HASHM' HARFORD

DHMH 16 Ray 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Flizabeth J. Roberts Tayl 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Parkville. Baltimore Oak Crest Village Care Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1916 If Under 1 Year 9. Birthplaca (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1□M 2XF Maryland 83 212-10-9407 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Parkville Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 #331S. 8832 Walther Blvd.. U.S.A. 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (2)(No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Green Garland Schaefer Elizabeth 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9214 Cornflower Road, Baltimore. MD 21236 Mrs. Donna L. Burke (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/20/00 Baltimore, Maryland Parkwood Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Buen C. W. Llew Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. 21236 Approximete Interval Between Onset and Deeth PNEUMONIA ASPIRATION Immediete Cause (Final disease or condition resulting in death) ENDSTAGE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) MINO Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d, Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physician and s the burial-transit Records, P.O. Box 68760, Physician/Medical the signed by t by Completed Division of Vital 89 Medical Certification: To this After

Physician

/Medical

Examiner

Funeral

Director

na 23a or 28a-f show must be notified at

Berns 23a

"natural", or

Important: if Isem 27 is marked other to any injury or other traumatic event, the once.

Physician

/Medical

Examiner

Pages 1 and 2 should be nent of Health and Mental

Director

p

Completed

Be

Hospital or Attending Physician: To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun.

State

Registrar

29b. Signature and titte of certified

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

ed cause of death (Item 23a) (Type, Print)

8800 (Walther Blud

Baltinar MD

29e. Certifier

(Check only one)

32. Registrar's Signature

of only,

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 2000 Month 19, BEATRICE A. RECKER Jan. 1:05 p.m. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Baltimore Baltimore Hours Min. Sept. 25, 1904 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland Months Days 1 □ M 2 🛛 F 95 Yrs. 220-44-3430 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8830 Walther Blvd. 21234 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X] No 14. Race - American Indian, 11 Merital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Yeer or Detes: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Estelle Theodore John Harvey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 11630 Glen Arm Rd.. Lorraine Springer (Daughter) Glen Arm. MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 □ Cremation 3 □ Removel from Stete Woodlawn Cemetery 1/22/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee Buan a.l Velley 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final I ScHEMIC HEART disease or condition resulting in death) Due to (or as a consequence of): 14 yer tensin Due to (or es a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physiclan/Medicai

by

Completed

Be

Certification: To

Medicai

Physician

/Medical

Examiner

Funeral

Director

show

280-1

"natural", or home 23s or

Hygians.

permit. Pages 1 and 2 ahouid be filled w Copartment of Health and Mental Hygien, important: if them 27 is marked other tha fathy injury or other traumatic other tha

Baltimore, Maryland 21215-0020

must be notified at

Directo

Funeral

à

Completed

Be

physician and s the burial-transit signed i the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifical npletely filled in by the funeral director,

Records, P.O. Box 68760

Division of Vital

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Conges line Heart failure 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Netural 2 ☐ Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) 730132 JANUARY 19 2000 W 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 3200 walter Blud Balkmore MD 21234 WILLIAM RUSSELL MD 31. Date filed (Month, Day, Year) 32. Registrar'a Signatura

State Registrar

JAN 2 1 2000

D. Sparks

To the I within 2 To the Comple

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #19a PER FH G780 2/7/2000 AH Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year **Physician** :40 jarlie 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Secoul ta Himure N/A If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ØM 2□ F S.C. Director 248.44-6920 15A Usual Residence of Decedant 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show MD. 1 PYS 2 No Directo N/A BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be. 1543 APPLETON ST. 21217 USA 'natural', or itsms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ¬Yas 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Marriad 2 → Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be d 2 should be fitted and Mental Fitter transfer out CHARLIE REAVES SR. BLOOMIE REAVES Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or other tra EDA REAVES (WIFE) 1543 APPLETON ST. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 8 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VETERANS 1-25-2000 OWINGS MILLS, MARYLAND 4 ☐ Donation - 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature et Funeral Service Licensee Hubner matha 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 TYes 2 TNo 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu within 2

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifiar,

ank

SAMBANDAM BAS KARAN 31. Date filed (MANPa2 YT') 2000 32 Registrer's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

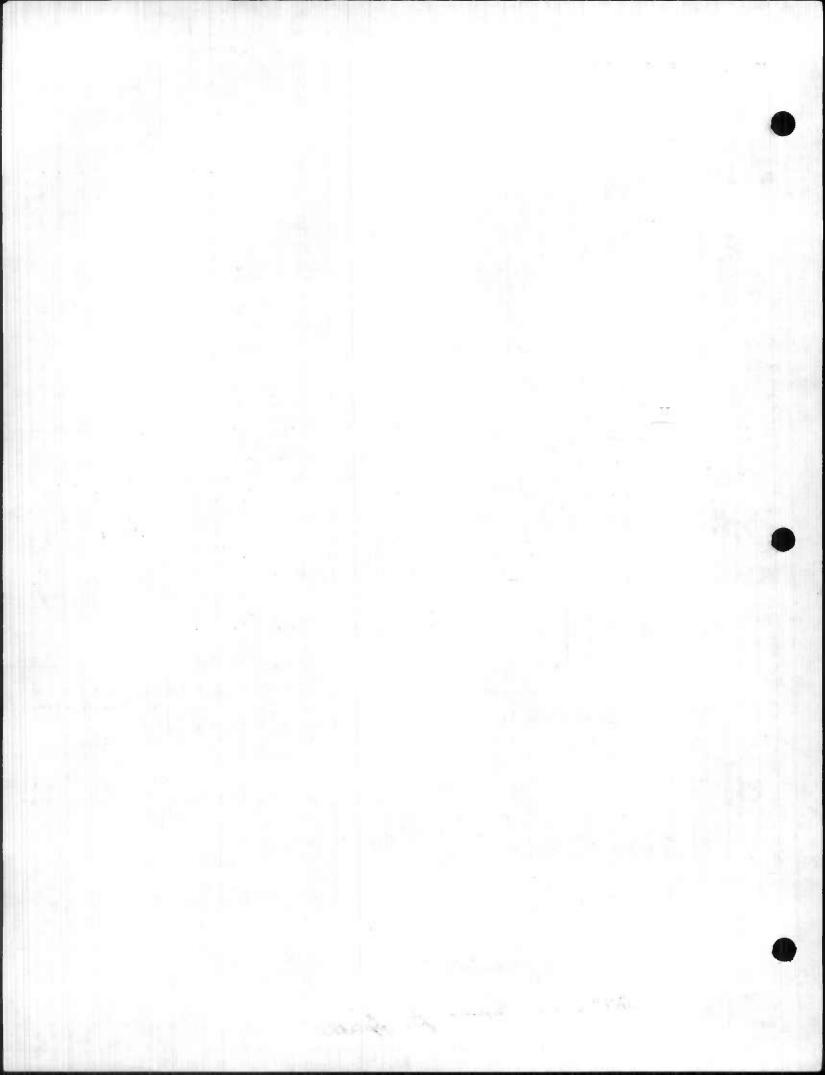
3455 Wilkens Avy Baltimore MD 21229

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

JAN 18, 2000

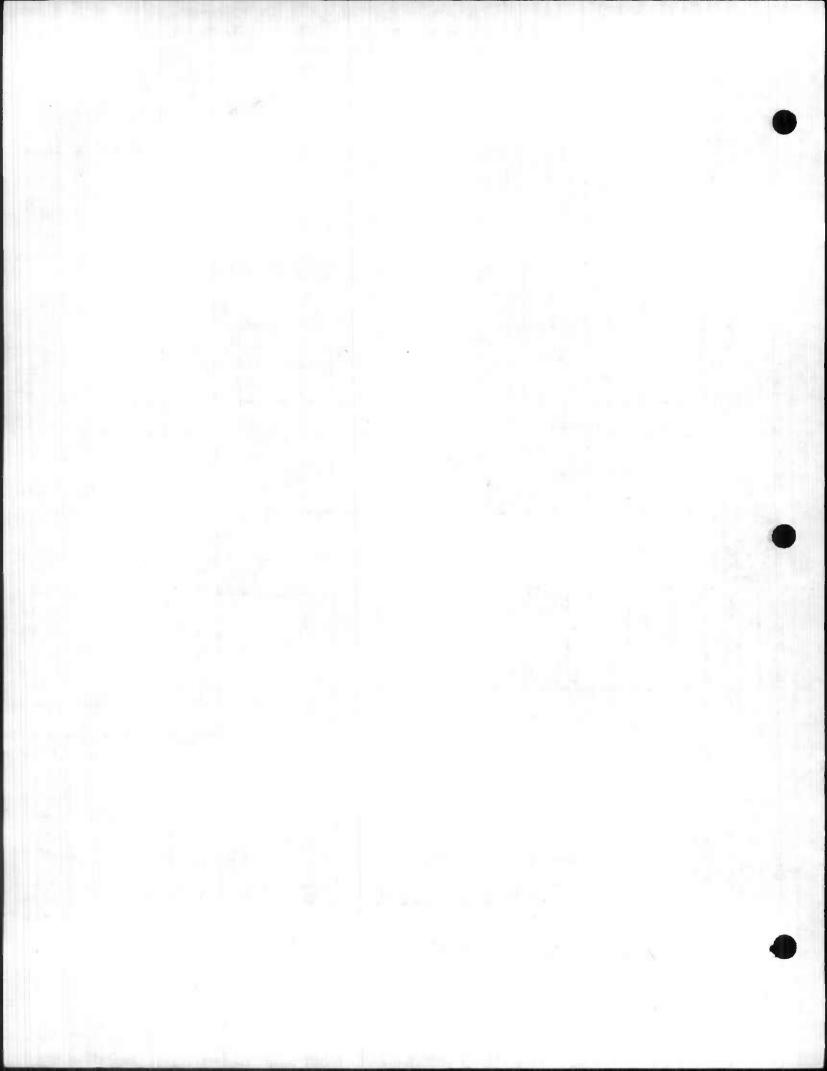


State of Maryland / Department of Health and Mental Hygiene 0 0 1 2 0 6

			Certifi	cate of L	Death		Reg. No.	U	1030
sician	1. Decedent's Name (First, Middle, L.	est)				2. Date of De Month	ath Dey	Year	3. Time of Death
edical	Anit	a G. Rahe				Januar	v. 14. 20	000	11:08 AM
miner	4a Facility Name (If not institution, gi	ve street and number)		4	b. City, Town, or i	Location of Death	4c. County	of Death	
	Cromwell Cent		Eldercar	e	Balti	more		Balt	imore
1		Sex 7. Age (In yr	Mo	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	9. Birthple	ace (State or Foreign
r	220-52-6029	91	Yrs.			NOV 1,			rmany
	Usual Residence of Decedent 10a. State 10b. County	10c. 6	City, Town or Locatio	n				10	d. Inside City Limits
5									1 ☐ Yes 2 ☑ No
ect	MD Balt	timore		Baltim	ore		40- 02		
Funeral Director		1	10	V. Zip Code	001		10g. Citizen of V		ry7
in a	8710 Emge Ro				234			JSA	
S	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13. Wes I	specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Hace Blec	e - America k, White, e	
by F	1 Never Merried 2 Merried 3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 🗆 Y	es 25 No	Specify:		Specify		
	**	Year or Dates:	1 40 5 4 4	1110	••		101 15 1 18	Whi	
010	15. Decedent's E (Specify only highest gr		16a. Decedent's	Usual Occupt of work done o OT use retired	luring most of wor	king	16b. Kind of Bu	siness/Ind	ustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)							
	17. Father's Name (First, Middle, Las	41	Home	maker	18. Mother's Nan	an /Circl Middle	Own I		
000					18. MOTHER'S NAM	ne (rirst, Middle,	Maiden Sumam	Θ)	
2	Conrad Gerho								teffens
	19a, Informant's Neme/Reletionship		H. III-		end Number or Ru				
	Lynnette Rapp		8350 B	letze	r Rd.,	Baltim	ore, MI	21:	222
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐		Place of Disposition cemetery, cremetor	(Name of y or other plac	e)	Dete	20c. Location -	City or Tov	vn, Stete
	4 Donation 5 Other (Speci		tro Crem	natorv	. Inc.	1/15/00	Balt:	imore	MD .
	21. Signature of Funeral Service Lice	osee / v	22. Nar	ne and Addres	s of Fecility				
	Edward A.	ista	cre	mation	n Socie	ty of	MD, Inc	·	01000
	23a. Part1. Enter the disease, or com	nplications that caused the de	ath. Do not enter the	mode of dying	erick R	oad ba	<u>l Elmors</u> rest.	2, MI	Approximate
	shock, or heart feilure. Distronly	one cause on each line.							Interval Between Onset and Deeth
	Immediate Causa (Finel							i	
	disease or condition resulting in death)	 Alzheim 							3 years
5		DU0 10	(or as a consequenc	e or):				1	
Examine		b.	(or as a consequenc	0.				-	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequenc	e (i).				1	100
3	Cause (Disease or injury that initiated events	C	(or es a consequence	a a0:				-	
ğ	resulting in death) Last	Due to	(or es a consequence	a Oi).					
\$		d							
S									
Physician/	Part II. Other significant conditions	contributing to death but not re	sulting in the underly	ring cause give	en in Part I.				the cause of death?
	coronary ar	tery disease	2			10	TSS ZUNO	3 🗆 Prob	ably 4 X Unknown
qp						24a Was	an autopsy	24h We	re autopsy findings
Complated							rmed?	ava	ilable prior to
de la								ot d	eath?
ō						10	Yes 2 No	10	Yes 2□ No
O		1				ath (Check only o	ne)		
	25. Was case referred to medical			Out.	BC: 4 TST Numino N	lome 5 Resid	dence 6 Othe	er (Specify)
8	25. Was case referred to medical axaminer? 1 ☐ Yes 2 ☒ No	Hospital: 1 tnpatient 2	☐ ER/Outpatient 3	DOA Othe	+ CA IAGISHIR L			ed	
200	axaminer? 1 Yes 2 X No 27. Manner of Death	28a. Date of Injury	28b. Time of	J DON	44	28d. Describe 1	now injury occurr		
200	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	1	28c. Injury Work	44		now injury occurr		
000	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 2 Accident 3 Suicide 6 Could not a	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work	r at	28d. Describe I	Street and Numb	er or Rural	Route Number,
0 0 0	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work	r at	28d. Describe I	Street and Numb	er or Rural	Route Number,
Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined. 29a. Certifier 1 Certifying Pl	28a. Date of Injury (Month, Day Year) 28a. Place of Injury 28a. Place of Injury - At building, etc. (Spec	28b. Time of Injury Nothern, street, fairly)	28c. Injury Work	Yes 2 No	28f. Location (S City or Tow	Street and Numbern, State)	nner as sta	ated.
Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined. 29a. Certifier 1 Certifying Pl	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Special	28b. Time of Injury Nothern, street, fairly)	28c. Injury Work	Yes 2 No	28f. Location (S City or Tow	Street and Numbern, State)	nner as sta	ated.
Medical Certification: To Be C	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exam	28a. Date of Injury (Month, Day Year) 28a. Place of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spec	28b. Time of Injury Nothern, street, fairly)	28c. Injury Work	r at (? Yes 2 □ No	28d. Describe I 28f. Location (Single or Tout) , end due to the tried at the time,	Street and Numbern, State)	nner as sta and due to	ated. the cause(s)
edical Certification: 10 Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28a. Date of Injury (Month, Day Year) 28a. Place of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Spec	28b. Time of Injury Nothern, street, fairly)	28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y at (?) Yes 2 No No, date end place pinion, death occurs a number	28d. Describe I 28f. Location (Scity or Town, end due to the rred at the time,	Street and Numbern, State) cause(s) and madate and plece, 4 29d. Date signed	nner as sta and due to d (Month, L	ated. the cause(s)
edical Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture and titla of certifier Thaman	28a. Date of Injury on 28a. Place of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (Special Place) 28a. Date of Injury -	28b. Time of Injury No.	28c. Injury work actory, office	r at (? Yes 2 □ No	28d. Describe I 28f. Location (Scity or Town, end due to the rred at the time,	Street and Numbers, State) cause(s) and made and piece, 4	nner as sta and due to d (Month, L	ated. the cause(s)
edical Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only onle) 29b. Signeture and title of certifier Wharan 30. Name and address of person who	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Date of Injury - At building, etc. (Special Place) 28a. Place of Injury - At building, etc. (S	home, ferm, street, filty) Nowledge, deeth occupation and/or investig	28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 29c. License D 2 2	yes 2 No Ne, date end place pinion, death occurs number 1.022	28d. Describe 1 28f. Location (City or Tou , end due to the rred at the time,	Street and Number, State) cause(s) and madate and plece, 4 29d. Date signed January	nner as str and due to d (Month, L	ated. the cause(s) Day, Year)
Medical Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier Check only one) 29b. Signeture and title of certifier Marion Kowale:	28a. Date of Injury At Day Year) 28a. Place of Injury At Duikling, etc. (Special Place) 28a. Place of Injury At Duikling, etc. (Special Place) 28a. Place of Injury At Duikling, etc. (Special Place) 28a. Place of Injury At Duikling, etc. (Special Place) 28a. Date of Injury At Duikling At Duikling, etc. (Special Place) 28a. Date of Injury At Duikling At Duikling At Duikling, etc. (Special Place) 28a. Date of Injury At Duikling At	home, ferm, street, faity) Nowledge, deeth occupation and/or investig	28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 29c. License 29c. License	yes 2 No Ne, date end place pinion, death occur a number 1022	28d. Describe 1 28f. Location (City or Tou , end due to the rred at the time,	Street and Number, State) cause(s) and madate and plece, 4 29d. Date signed January	nner as str and due to d (Month, L	ated. the cause(s) Day, Year)
edical Certification: To Be	axaminer? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only onle) 29b. Signeture and title of certifier Wharan 30. Name and address of person who	28a. Date of Injury - At building, etc. (Special mysician: To the best of my kinder of manner: On the basis of examinand manner stated. **Total Design of Examination of	home, ferm, street, fishy) howedge, deeth occupation and/or investig	28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 1 28c. Injury Work 29c. License 29c. License	yes 2 No Ne, date end place pinion, death occur a number 1022	28d. Describe 1 28f. Location (City or Tou , end due to the rred at the time,	Street and Number, State) cause(s) and madate and plece, 4 29d. Date signed January	nner as str and due to d (Month, L	ated. the cause(s) Day, Year)

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month REINTZell 4:10A.M MARIA 8,2000 anuary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Baltimore Hospital Center | 17. Age (In yrs. last birthday) | HUnder 1 Year | Moriths | Days Square osedale 5. Sociel Security Number If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Hours 217-03-2052 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show show MD 1 Yes 2010 BALTIMORE Kosedale **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or RoseDAIR Heights 2173 U.S. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Rece - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: white Completed by 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 13+1 NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be in nent of Health and Mental I in: If Item 27 is marked of Chochlowski UNKNOWN ALEXANDRA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) RoseDele MD, 21237 16.3 Rosidale Heights Ave MADISON (DAUGHTER If Nem or other 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2000 permit. Page Department of Important: If any Injury or MARKWOOD BATTU. Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Furreral Hone (HTD. 21. Signature of Funeral Service Licensee HARTLEY Miller 7527 HARFORD tella BAMOIND 21074 KD. 23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner 1ac Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): oronary sease Artery Physician/Medical 6 Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? ronic Hnemi 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 200 27. Menner of Death 28b Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation Attending 1 Netural if or Attending sher death. 1 | Yes 2 | No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Puneral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

Astronomy Complete

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2000

Ka

M

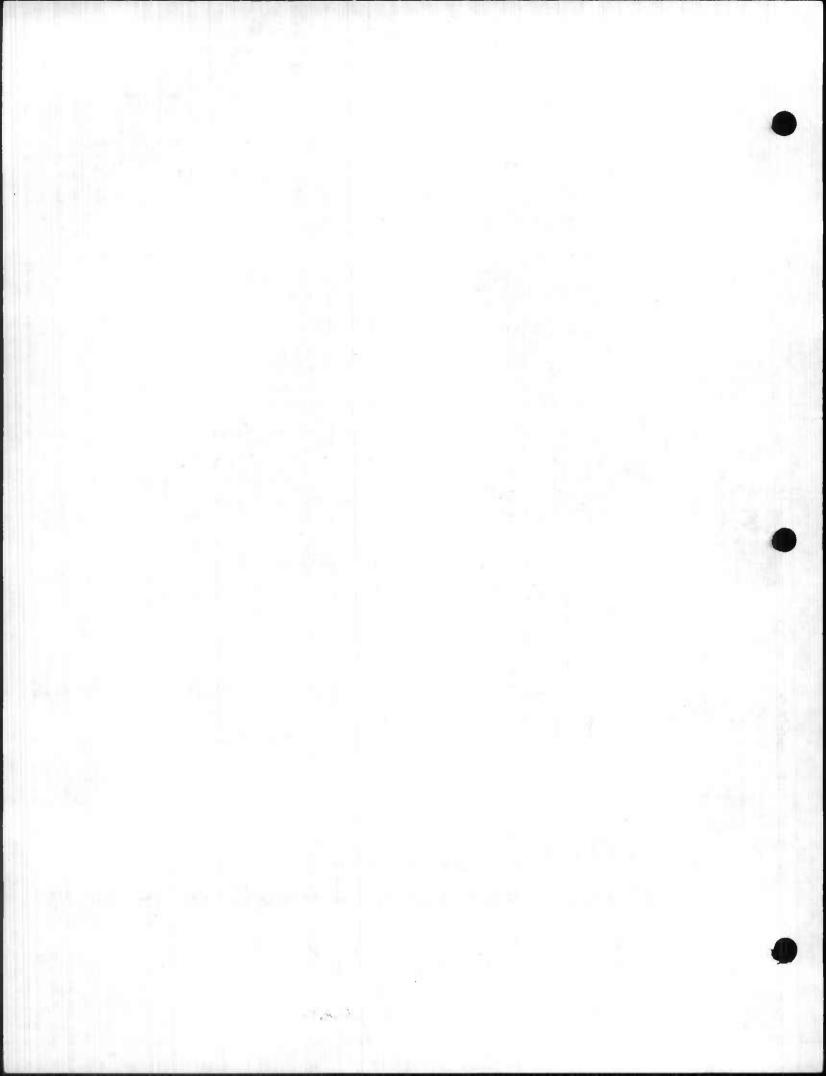
30. Name and address of person who completed cause of death_(Item 23a) (Type, Print)

32. Registrar's Signature

eem

100 Franklin Square Drive Baltimore, MD21235

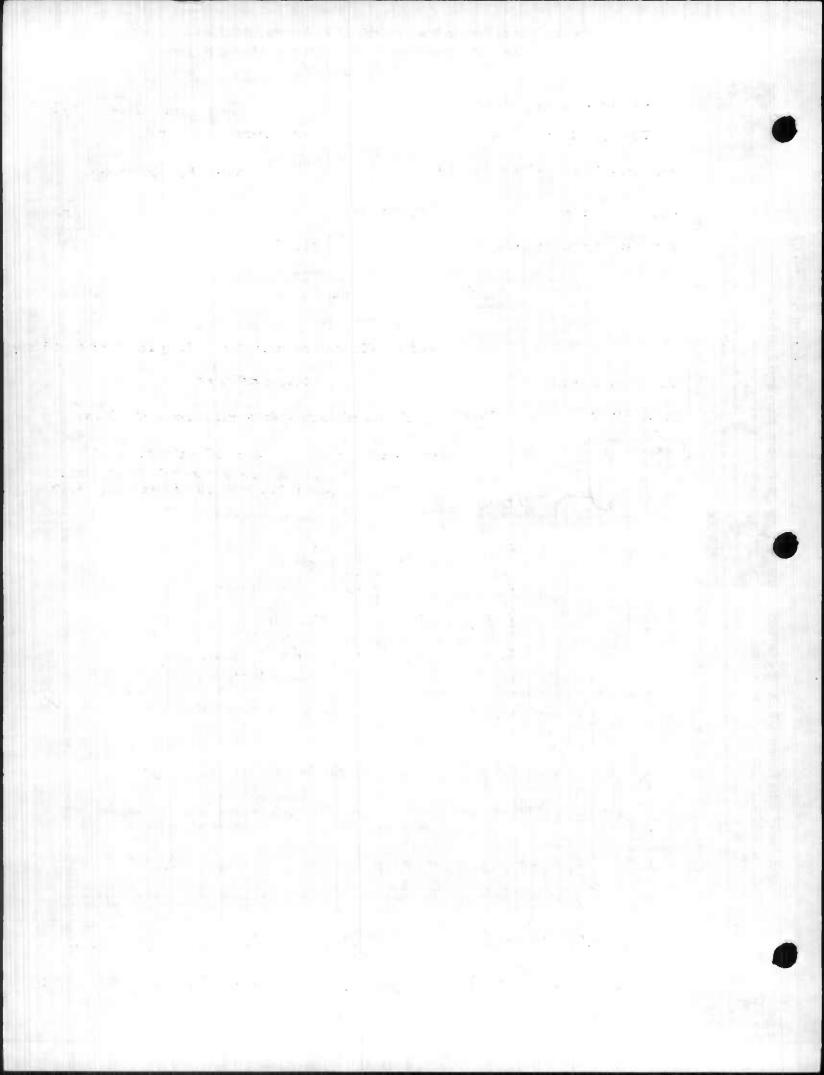
8,2000



DHMH 16 Ray 6/95

Registrar

JAN 21



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Florentine Rethemeyer 2000 6:20 PM 4b. City, Town, or Location of Death /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SQUARE HOSPITAL

POR DESERVE TARA HOUSE Rosedale If Under 24 Hrs. 8. Det BAITIMORE CenTer birthday) If Under Aga (In yrs. last birthday) 81 Yrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 1□ M 2X F Months Min. 215-14-4307 Days Hours Director Sept. 19.1918 MD Usual Rasidence of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Nas 2 No Director 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 6401 Loch Raven Blvd. USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2☐ No If Yas, Give^A Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 21215-0020 ò 1 Yas 2 No Specify: white þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Homemaker Own Home Saltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental George A. Reich Florence Cerf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Janice Whitmore / daughter 1385 Harford Square Dr. Edgewood, MD 21040 mportant: If Ihem 27 any injury or other to 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 1 - 20 - 00Parkville, MD 21. Signature of Funeral Service Lines 22. Nama and Addrass of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Part. Swer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical Ventricular fibrillation 2 MINUTES Examiner Examiner ARTER ORONARY The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760, Completed by Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown Pulmona 24b. Ware autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical examinar?

1 Yes 2 No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Invastigation 1 Natural 1 Yas 2 No 24 hours after death. 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, lactory, office building, atc. (Specify) filled in by 4 ☐ Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a, Certifian Medical within 24 ho To the Fune completely f (Check only one) the th 29b. Signatura and titla of certifian 29d. Data signed (Month, Day, Year) JANUARY 17, 2000

State Registrar

DR. SerenA

31. Data liled (Month, Day, Year)

DHMH 16 Rev 6/95

emayer

2

OREN

FRANKlin

SEUARE DR. BAITIMORE MARYLAND

30. Nama and address of person who completed cause of death (her 23a) (Type, Print)

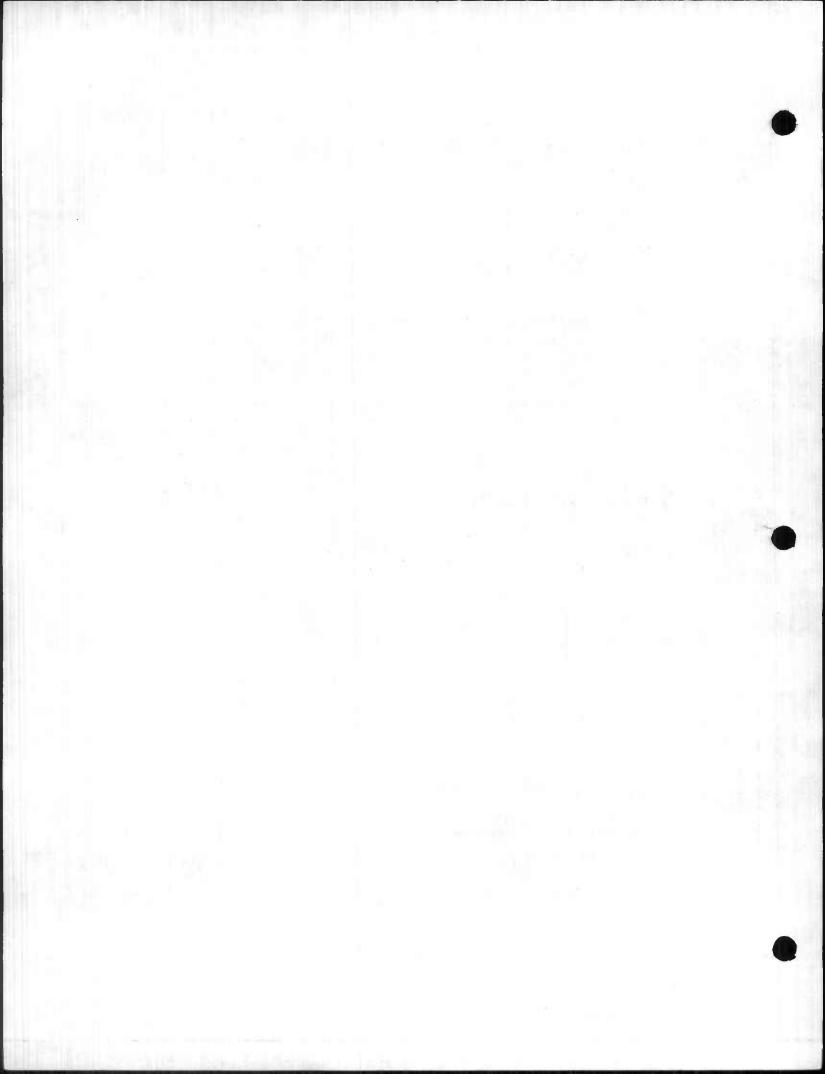
2000

Klug

JAN 21

9000

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Day Year **Physician** 1 Curtis Keynolds 19:50 Pais 2000 16 JANA /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days 1□ M 25 F 63 Hours Yrs. 219-26-3563A **Director** 08-24-36 NC Usuat Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 1 Yes 2 No MD Director NA Baltimore 28s-f must be notif 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 23a or USA 302 Grantley Street 21229 Funeral Merre 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nam of Health and Mental Hyglene. Int. If Item 27 Is marked other than "natural", or ite Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: À 3 Widowed 4 Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory worker Laundry 4th Grade NA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be David Reynolds Callie 21218 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) ni of Health a iff them 27 is or other tra Rebecca Alston 1814 E. 29th Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 01-21-2000 Woodlawn, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue tre 23a. Part1. Enter the disease, or complications that caused the small. To not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Terminal Chronic obstructives duegoe disease or condition resulting in death) Examiner Examiner bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical the Due to (or as a consequence of): signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera sutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peed certificate has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 BNetural s after death. If Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Medical 29e. Certifier 1년 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.

Registrar

DHMH 16 Rev 6/95

4

21215-0020

Baltimore, Maryland

The lew requires that the death certificate be executed

Physician:

Box 68760,

P.0.

of Vital Records,

Division or Attending

> Rm 206 31. Date filed (Month, Day, Year) 32. Registrags Signature 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

am, duraly

29b. Signature and title of certifier

mion-0

min - Day KiDure

29c. License number

D31865

cutan street

29d. Date signed (Month, Day, Year)

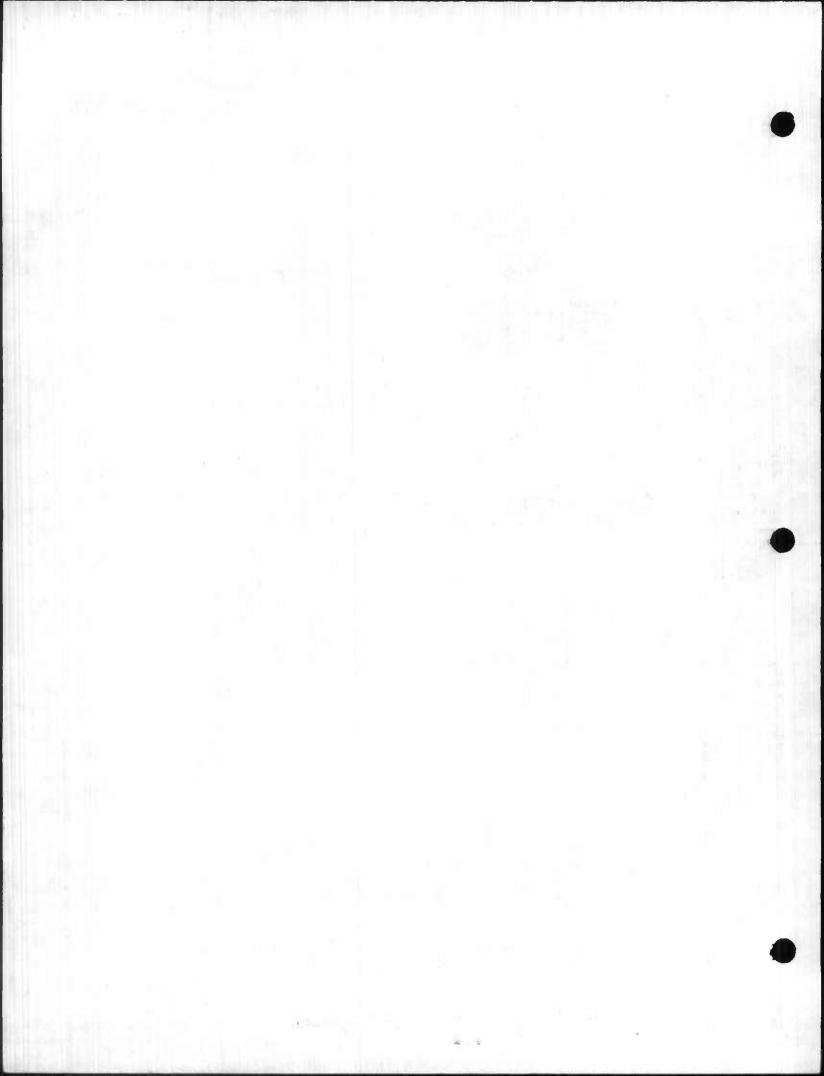
md 2/20/

1-19-00

Baltimore

ORIGINAL

821



Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

the

941 detached

3

director, page 2 should be

certificate has

this

After

after death.

filled in by

P.O.

Records.

of Vital

Division

or Attanding Physician:

Hospital

within 2 To the

Due to (or es a consequence of)

23b. Did tobacco use contributa to the cause of death? Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were sutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2□No 19 Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 11 Yes 2 No 28b. Time of A 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 5 Panding investigation 1 Naturat 2 Accident SUBJECT SUFFOCATED 1 Yes 2 No 1-13-2000 4:00 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number of Rural Route Number, City or Town, Stete) 1 1 N . AMITY ST. 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide RESIDENCE

BALTIMORE, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signeture and title of certified

29c. License number OCME

29d. Date signed (Month, Day, Year) JANUARY 13, 2000

3 Time of Death

MD

117 Yes 2 No

04:55 AM

Willinte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State

Medical

29a. Certifier

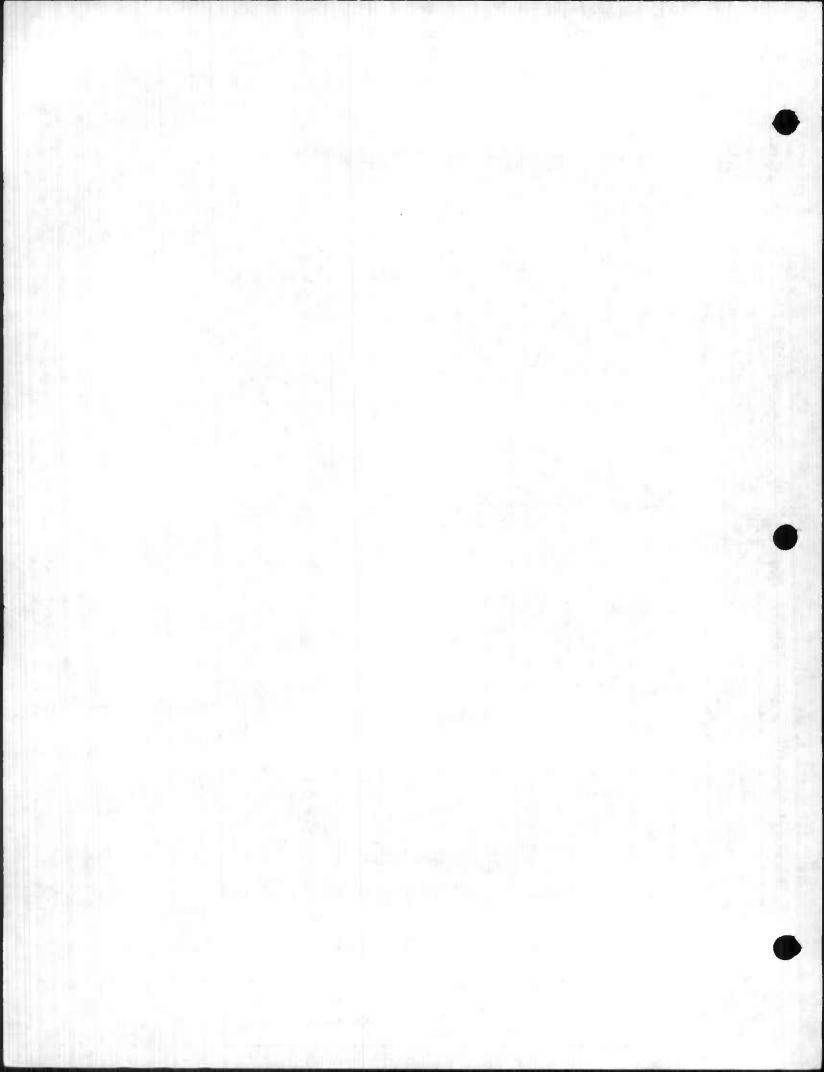
31. Dete filed (Month, Dey, Year) JAN 21 2000

HARDARITS

Wath an 32. Registrar's Signature

oaks

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bernice Joanna Richowsky 12:25 AM 15 2000 January 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Timonium Stella Maris Hospice Year If Under 24 Hrs. Days Hours Min. 5. Social Security Number If Under 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 2XXF Months 153-03-9551 88 July 26, 1911 New Jersey Usual Residence of Decedent 10s State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Clifton New Jersey Passaic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 07013 United States 27 Campbell Ave. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Never Merried 2 ☐ Married white 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Sudol Francis Yurek 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Friendship, MD 20758 P.O. Box 17 John C. Richowsky/son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 1/19/00 Baltimore, Maryland Greenmount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signefure of Funeral Service Licensee 22. Name and Address of Facility itchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. a 21212 Baltimore, MD 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final diseese or condition resulting in deeth) CEREBROVASCULAR ACCIDENT Due to (or es a consequence ot) Sequentially list conditions, if any, teeding to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably WUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steled. (Check only

P.O. The law requires that the Records, of Vital Division Attending 8 Hospital **Physician**

/Medical

Examiner

Funeral

Director

28a-f

8 8

mant b

Hygiens.

1 and 2 should be Health and Mental

Pages ъ

Health

Item 27

Physician /Medical

Examiner

burial-transit

the

100 990

2

has page 2 certificate

death.

after death Director:

24 hours a

within 2 the th

filled in by

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

21215-0020

Maryland

anuary

RICHOWSKY

BERNICE

Directo

Funeral

py

Completed

DHMH 16 Ray 6/95

State Registrar

31. Dete tiled (Month, Day, Year)

TARIQ MAHMOOD

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

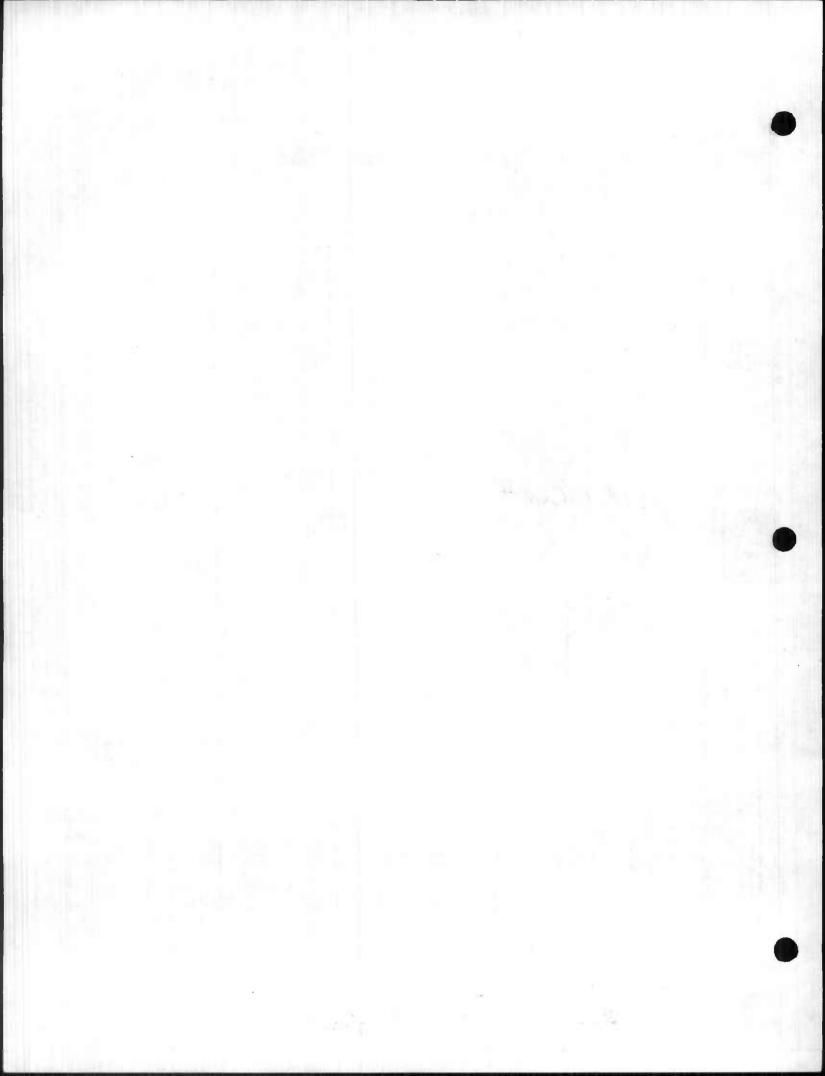
2300 DULANEY VALLEY RD. 32. Registrar's Signeture

TIMONIUM, MD 21093

29c. License number

1)43720

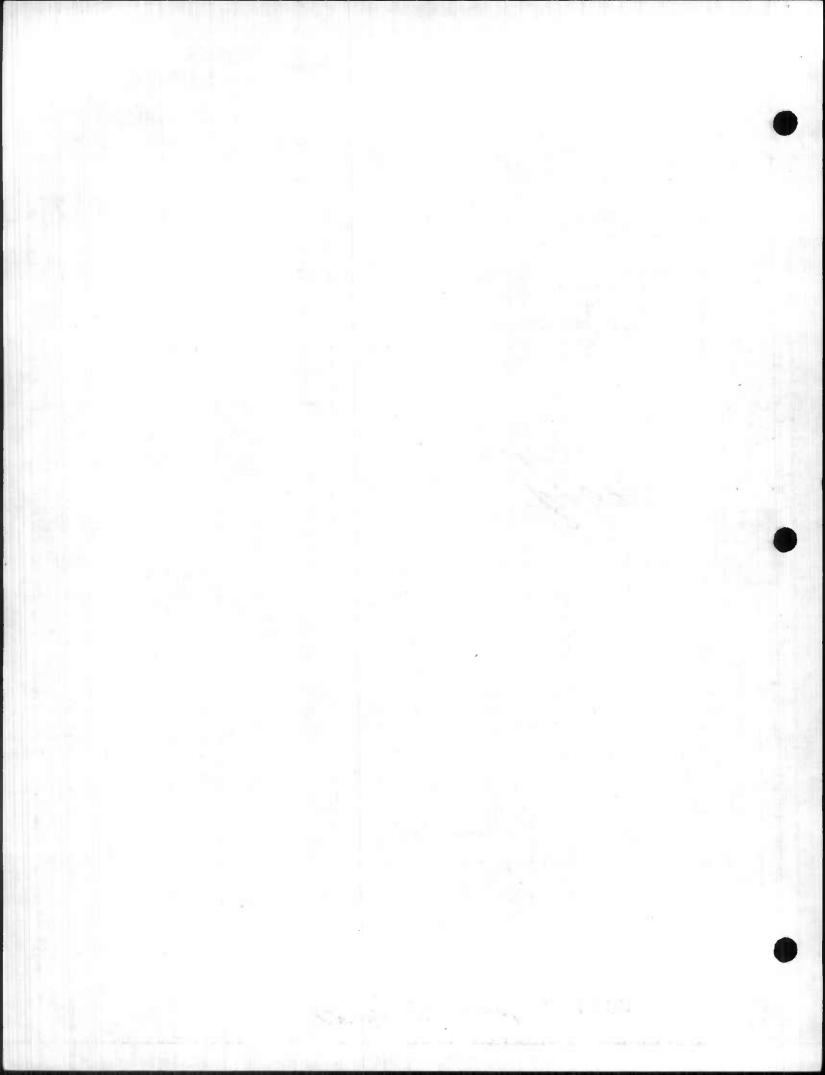
29d. Dete signed (Month, Day, Year) 8/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month January 10, av-Physician 18,2000 Rose Dorothy Roemer 8:45 A.M /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age Lenter Kosedale Baltimore 8. Date of Birth (Month, Dey, Y 2/7/1904 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2⊠F Months Hours 217-26-1343 95 Maryland Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Perry Hall 1 ☐ Yes ZINo Director 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or death with 4302 E. Joppa Road 21236 U.S.A. Funeral Heme 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indien 11. Merital Stetus Bleck, White, etc. other treumstic evant, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: if Nem 27 is marked other than "natural", or its 1 Never Merried 2 Married Maryland 21215-0020 ò 1 Ves 2K No Specify: by White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Rose Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) William Rauber Rosa Hauf emer, 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Irvin Roemer /Son 4302 E. Joppa Road Baltimore, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stete
4 Donation 5 Other (Specify) Injury or permit. Pag Department Important: If any injury o 1/20/00 Laurel, Maryland Balto/Wash. Crematory 0 21. Signature of Furjeral Service Licena John C. Miller Inc. 22. Name and Address of Fecility 6415 Belair Road Baltimore, Maryland 21206 23a. Part 1. Emer the diagonal or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical neumonia Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760, Due to (or as a consequence of): tor usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Disease, Myocardia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? on Congestive Heart hes 25. Was case referred to/medical examiner? this certificata 1 Yes 1 ☐ Yes 2 ☐ No Physicien: 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) funerai 27. Manner of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Netural 2 Accident or Attanding 5 Pending investigation s after death.

I Director: Aft
od in by the fur 1 Tes 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homlcide To the Hospital or within 24 hours at To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and my inner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (frem 23a) (Type, Print) 30. Name and address of person who Drive Baltimore, MD 2123 tranklin amo Aegistrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death 1. Decedent'a Neme (First, Middle, Last) Month De Yee 19,2000 Yolanda A. Scharf JANUARY 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Mercy Hospice-Stella Maris Baltimore If Under 24 Hrs 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Months Hours 1 M 2 X F 73 214-20-8412 Yrs Baltimore, Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore n/a 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 229 South Grundy Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Meritel Stetus Bleck, Whita, etc 1 Never Merried 2 Merried White 1 Ves 28 No Specify Specify: 3K Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Goetz Candy Company Assembly Line Worker 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fether's Neme (First, Middle, Last) Famnie Garmino Anthony Rossi 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8218 Beach Drive, Baltimore, Maryland 21222 Anthony Vega 20b. Place of Disposition (Name of cametery, cremetory or other place) Sacred Greenmount Crematory of Jesus 20e. Method of Disposition Deta 20c. Location - City or Town, State 1 X Burial 2 X Cremetion 3 Removel from State 1/21/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yas 20 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) STE/IA MARIS AT MERE Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOS pick Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760, 98 980 P.O. 94 Division of Vital Records, page 2 s has or Attending Physician: this s after death.
I Director: After the ord in by the funera To the Hospital o within 24 hours at To the Funeral Di

Physician

/Medical

Examiner

Funeral

Director

28a-f show

b must be

flerns 23a

permit. Pages 1 and 2 should be fitted within 72 hours after a Department of Health and Mental Hygiene. I interest the It is merked other team "natures", or her any Injury or other traumette even.

Physician

/Medical

Baltimore, Maryland 21215-0020

MD

Director

Funeral

À

Completed

Be

the Maryland

Examiner Physician/Medical ò Completed Be 10 Certification:

edicai

25. Was case raferred to medical exeminer? 1 Yes 2 No 27. Manner of Death 1 Naturel

4 ☐ Homicide

29a. Certifier

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to the cause(s) and manner as stated

[Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and manner steled. (Check only one) 29b. Signeture and title of certifie 29c. License number U M

29d, Dete signed (Month, Dav. Year) JANUARY

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print) RISE BERG DAVID

ST

BAHIMORE

State Registrar

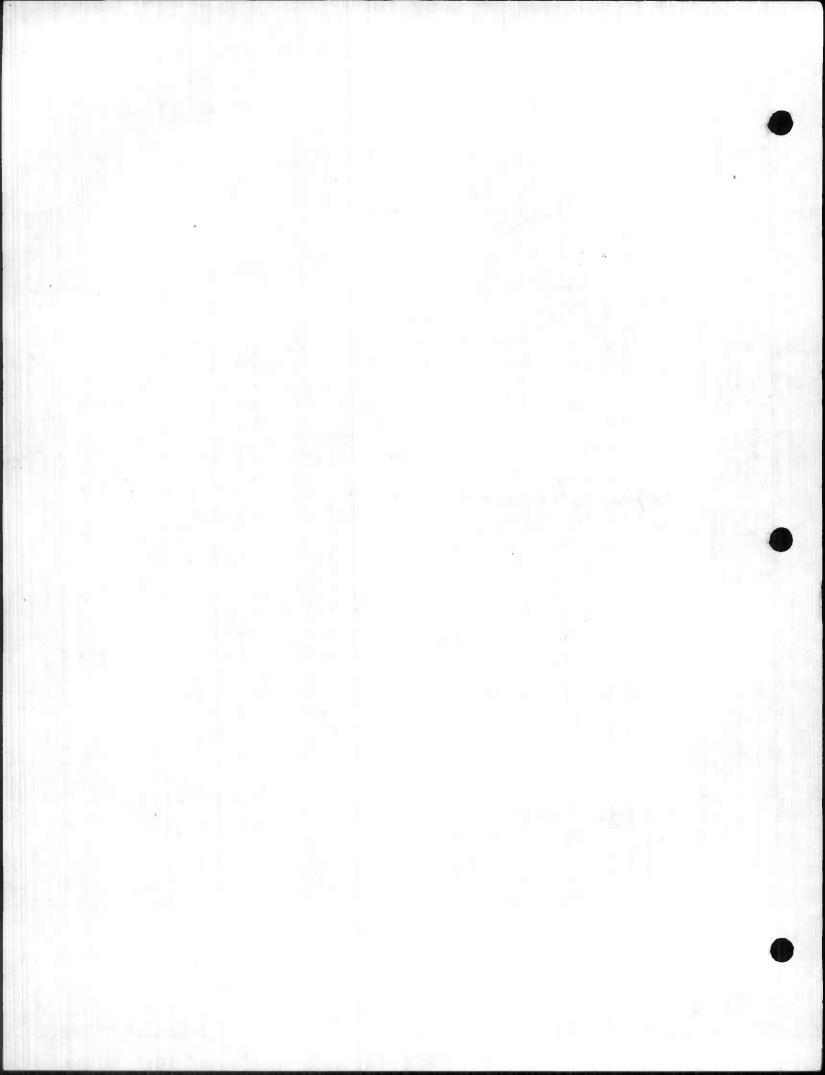
completely

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)





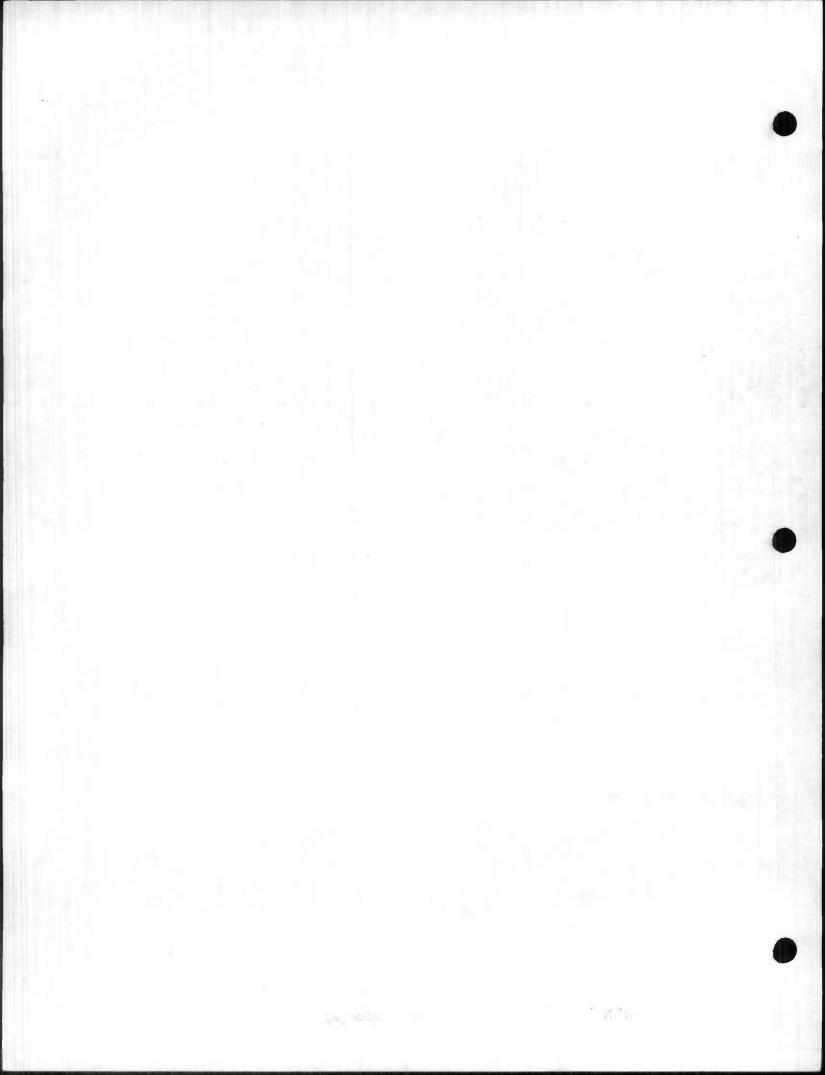


Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

	1. Decedent's Nam	AO (FIFST, MICICIA /	(ast)						2 Date	a of Death			3. Tima of Deatl
Physician		1. Decedent's Name (First, Middle, Last) Mary Claire Stang							Mor	nth	Day	Year	6:40 pr
/Medical	4a Fecifity Nama			nhar)			1	4h City Town		nuary	4c. County		01-10 pr
Examiner			Circon - I - I	noer)				4b. City, Town, or Location of					
	5. Social Security I	Maris Hos	_	7 4 //	80 fr 2-06-d-	If I lod	ler 1 Year	Towson		-f (D) -ti		imore	
Funeral Director	212-05-1	1842	Sex 1 M 2 F	7. Age (In yrs. 86	Yrs.	Months			in. (Mor	of Birth oth, Dey, Y ember	10, 1	9. Birthpl Count 912	lace (State or Fore lry) Maryland
Š u	10a. Stata	10b. County		10c. Ci	ity, Town or	Location						10	Od. Insida City Lim
or zite feb he notified Director	MD					_					Y□Yes 2□N		
2 2 2	10e. Street end Number 600 Light Street				10f. Z	10f. Zip Code 21230			10g. Citizen of What Country? United States				
Examiner man		ried 2 Married	Armed For 1 Yas If Yes, Give	1 TVes 2EINo			Nas Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puarto Ri			cify Yas or No- lican, atc.) 14. Race- Black, Specify:		k, Whita, a	
Note: The Medical Completed	(Spe Elementary/Sec 1.2	15. Decedent's ecify only highest g ondary (0-12)	Education grade completed) Coilega (1	-4or 5+)	16a. De (Gi lifa		sual Occup work done use retire	petion during most of (od)	vorking	16		phone	lustry e/ ephone
ent B		Affirm Advisor 4 -	-at			CI	erre		la and defined	5.4°-4-8'- 5.4-	-24		
	17. Father's Nama	Werner	St)							Maiden Sumema)			
marked matic e						- 787	- 10		Eyer:	-	0	Can Can Ta	Codel
27 le	19a. Informant's N Thomas		ersa, Jr.	/nephe				tand Number or ain Road					Coda)
ury or othe			☐Removal from S	State	Place of Dis cometery, co oudon	rematory or	r other ple		1/21		oc. Location -		wn, Stata Maryland
Importa	21. Someture of Funeral Service Licensee Location Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229												
	Immediata Causa	(Final	emplications that ce ly ona cause on as		th. Do not e	Baltinentar the mo	more, oda of dyi	, Maryla	ind 21:	229		lkens	Approximata Interval Between Onset and Death
dical niner	Immediata Causa disease or conditi resulting in death)	(Final on		EBROVAS Due to (CULAR or as a cons	Baltinentar the mo	more ode of dying the desired of the	, Maryla	ind 21:	229		Ikens	Approximata Interval Between
as the burlai-travait as the burlai-travait dedical Examiner	Immediata Causa disease or condition	(Final on onditions, mmediata ertying s		EBROVAS Dua to (c	CULAR	Baltinentar the mo	more, oda of dyi	, Maryla	ind 21:	229		lkens	Approximata Interval Between
g physician and as the burdal-fundal as the burdal-fundal edical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death)	(Final on	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the mo	more, oda of dyi	, Maryla	and 212	229 atory arras	st,		Approximate Interval Between Onset and Death
of by the attending physician and section of the standing physician and section of the section o	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Undicause (Disease or that inhitated event	(Final on	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the mo	more, oda of dyi	, Maryla	and 212	229 atory arras	ecco use cor	ntribute to	Approximata Interval Between
gned by the attending physician and be detached for use as the burishment by Physician/Medical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death)	(Final on	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the mo	more, oda of dyi	, Maryla	and 212 liac or raspire	229 atory arras	ecco use cor s 2□ No	atribute to 3 Prob	Approximate Interval Between Onset and Death
gned by the attending physician and be detached for use as the burishment by Physician/Medical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death)	(Final on	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the mo	more, oda of dyi	, Maryla	and 212 liac or raspire	229 atory arras b. Did tob	st, ecco use cor s 2 No autopsy ed?	ntribute to 3 □ Prote 24b. We ave core of c	Approximate Interval Between Onset and Death Onset and Death of the cause of death of
ilicate has been signed by the attending physician and or, page 2 should be detached for use as the butal-transit action or, page 2 should be have been sometiment or completed by Physician/Medical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) Part If. Other significant or the condition of the	(Final on onditions, mmediata ertying r injury is Last	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the mo	more, oda of dyi	, Maryla	and 212 liac or raspire	b. Did tobe 1 Yea a. Was an performe	st, ecco use cor 2 No autopsy ed?	ntribute to 3 □ Prote 24b. We ave core of c	Approximate Interval Between Onset and Death Onset and Death of the cause of death of the cause of death?
oerificate has been signed by the attending physician and rector, page 2 should be detached for use as the burishtmant auriped Be Completed by Physician/Medical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death) Part If. Other significant cause.	(Final on	a. CERF b	Due to (c	CULAR or as a cons	Baltinentar the monature of sequence of se	more, oda of dyi	yen in Part I.	and 212 liac or raspire	b. Did tob. 1 Yes Was an performed to make to only one.	st, secco use cor s 2 No autopsy s 2 No	24b. Wa ave cord of a	Approximate Interval Between Onset and Death Onset and Death of the cause of death of the cause of death?
In an antificate has been signed by the attending physician and a director, page 2 should be detached for use as the butal-transit. To Be Completed by Physician/Medical Examiner.	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death) Part If. Other significant or in the condition of	(Final on	a. CERF b c d contributing to de Hospitat: 1 to to (Monti	Due to (c	CULAR for as a cons	Baltinentar the mo	DENT (1): (2): (2): (3): (4): (5): (6): (7): (7): (8): (8): (9): (1): (1): (1): (2): (2): (3): (4): (4): (5): (6): (7): (7): (8): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (4): (5): (6): (7): (7): (7): (8): (9): (9): (1):	yen in Part I.	and 212 liac or raspire 23 24 24 Death (Check	b. Did tobi 1 Yes a. Was an performe 1 Yes k only ona.	st, secco use cor s 2 No autopsy s 2 No	24b. Wa ave cord of a sar (Specify	Approximate Interval Between Onset and Death Onset and Death of the cause of death of the cause of death? If the cause of death of the cause of death? If yes 2 \sum No
The death. Director: After this certificate has been signed by the attending physician and important in by the funeral director, page 2 should be detached for use as the burishtnant ariginal properties of the control of the contro	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) Part If, Other algnitudes of the condition of the causarriner? 25. Was casa refarantmen? 1 Yas 2 20	(Final on	a. CERF b	Due to (c	CULAR for as a construction or as a construction of the constr	Baltinentar the mo	more, oda of dyi	yen in Part I. 26. Place of Iher: 4 Nursin	23 24 Death (Check g Homa 5 [28d. De	b. Did tob. 1 Yes 1 Yas k only ons Rasiden	st, secco use cor s 2 No autopsy ed? s 2 No co 6 NOthi	ar (Specif)	Approximate Interval Between Onset and Death Onset and Death of the cause of death of the cause of death? If the cause of death of the cause of death? If yes 2 \sum No
Nours after death. Funest Director: Also this conflicate has been signed by the attending physician; and many filled in by the funest director, page 2 should be detached for use as the buttal-transit and properties of the funest director. To Be Completed by Physician/Medical Examiner	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death) Part If. Other algnit Part If. Other algni	(Final on	a. CERF b	Due to (c Due to (c Due to (c Due to (c Due to (c) Due to (c)	CULAR or as a cons or as a cons or as a cons sulting in the	Baltinentar the mo	more, oda of dyi	yen in Part I. 26. Place of I her: 4 Nursin hy at 1/2 No	23 244 Death (Check g Homa 5 [28d. De 28f. Loc City	b. Did tobe 1 Yes a. Was an performe 1 Yas k only ona; Rasiden scribe how	st, st, secco use core s 2 No autopsy ed? s 2X No) nce 6 X Othi w injury occurr set and Numb Stete)	24b. Was ave cor of contribute to ar (Specif) red	Approximate Interval Between Onset and Death Onset and Death of the cause of death of the cause of death? If the cause of death of the cause of death? If the cause of death of the cause of death? If the cause of death of the cause of death? If the cause of death of death of the cause of death of death of the cause of death of d
Persons affect death. Funeral Director, After this coefficies has been signed by the attending physician and new funeral director, and a second by the description of the funeral director, page 2 should be detached for use as the burial-transit and signal coefficient of the funeral director of the funeral director of the funeral detachment of the funeral detachment of the function of the functio	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) Part If. Other significant in the condition of the cause (Disease or that initiated event resulting in death) Part If. Other significant in the cause (Disease or that initiated event resulting in death) 25. Was casa refar axaminer? 1 Yas 2 Zi 27. Manner of Deat 1 Zi 28. Accident 3 Suicide 4 Homicide 29e. Certifier (Check only)	rred to medicat No th S Pending invastiget INC Certifying F 2 Medical Exc	a. CERF b c d Hospitat: 1 tr contributing to de contributing to de contributing to de d 28a. Data o (Montri contribution) 28e. Place building Physician: To that barminer: On the ba	Due to (c Due to (c Due to (c Due to (c Due to (c) Due to (c)	CULAR or as a cons or as a cons or as a cons sulting in the	Baltinentar the mo	more, oda of dyli DENT (1): 1): 1): 1): 1): 1): 1): 1)	yen in Part I. 26. Place of I her: 4 Nursin hy at 1/2 No	23 244 Death (Check g Homa 5 [28d. De 28f. Loc City	b. Did tob. 1 Yes a. Was an performed to the cause time, det	st, st, secco use core s 2 No autopsy ed? s 2 No) ace 6 Noth winjury occurr set and Numb Stete) use(s) and ma te and place, it	24b. Was ave cor of contribute to a refer or Rura and due to do (Month.)	Approximata Interval Between Onset and Death Onset and Death of the cause of death of the cause of death? I would be the cause of death?
in 24 hours after death. ** Funeral Director: After this certificate has been signed by the attending physicial pletely filled in by the funeral director, page 2 should be detached for use as the burnel call carl Certification: To Be Completed by Physician/Medical	Immediata Causa disease or condition resulting in death) Sequentially fist or if any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death) Part If. Other significant initiated event resulting in death) Part If. Other significant initiated event resulting in death) 25. Was casa refaranaminer? 1 Yas 2 2 2 2 2 2 2 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one)	rred to medicat In Certifying F S Pending invastiget 6 Could not detarmine In Certifying F Certifier In Certifier	a. CERF b c d Hospitat: 1 tr contributing to de contributing to de contributing to de d 28a. Data o (Montri contribution) 28e. Place building Physician: To that barminer: On the ba	Due to (c Due to (c Due to (c Due to (c Due to (c) Due to (c)	CULAR or as a cons or as a cons or as a cons sulting in the	Baltinentar the mo	more, oda of dyli DENT (1): (2): (2): (3): (4): (5): (6): (7): (7): (8): (8): (9): (1): (1): (1): (1): (2): (3): (4): (5): (6): (7): (7): (7): (8): (8): (9): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (9): (1): (1): (1): (1): (1): (2): (3): (4): (4): (5): (6): (7): (7): (7): (8): (8): (9): (9): (1): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (4): (5): (6): (7): (7): (7): (8): (9): (1): (1): (1): (1): (1): (1): (2): (3): (4): (4): (4): (5): (6): (7): (7): (7): (8): (9): (1):	yen in Part I. 26. Place of ther: 26. No Nursin my at wit? 27 Yas 2 \(\text{No} \) No ime, date and place opinion, deeth opinion, deeth of the control of the control opinion, deeth opinion, deeth of the control opinion, deeth of the control opinion, deeth of the control opinion, deeth opinion opinion, deeth opinion, deeth opinion opinion, deeth opinion opinion, deeth opinion opinion, deeth opinion opinion opinion.	23 244 Death (Check g Homa 5 [28d. De 28f. Loc City	b. Did tob. 1 Yes a. Was an performed to the cause time, det	st, st, secco use core s 2 No autopsy ed? s 2 No) ace 6 Noth winjury occurr set and Numb Stete) use(s) and ma te and place, it	24b. Wa ave cor of core ar (Specify red	Approximata Interval Between Onset and Death Onset and Death of the cause of death of the cause of death? I would be the cause of death?

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 40 Dears 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Richey Hospice Joseph 5. Social Security Number yrs. lest birthday) If Under 1 Year South Caroline 6. Sex **Funeral** Deys 1X) M 2□ F 48-863 **Director** Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits nem 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo nore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 d Funeral Thwa 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Reca - American Indian 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1□ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) To Be ea (Friend) 19b. Melling Address (Street and Number or Rural Route Number, Balto, Md. 2/2/5 200. Place of Disposition (Name of cemetary cremetory or other place) Department of Heelth Important: If Item 27 20a. Method of Disposition 20c. Location - City or Town, Stete any injury or o 1 Buriel 2 Cremetlon 3 Removel from State sdowne -10m 4 □ Donetton 5 □ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name end Address of Secility JOSEPH L. KUSS FUNERA 23a. Pent /Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Metastatic /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Metastatic f Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last attending physician end for use as the buriel-tran Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of). SAMMIE SPEARS 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 3 Probably 4 Unknown 1 Yes 2 No P 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes an autopsy performed? certificate has 1 Yes 25 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospi'c Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deetl 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 TYes 2 □ No after death Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital within 24 hours of To the Funeral edical 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) et! 29b. Signature and title of certifle 29c. License number 29d. Dete signed (Month, Day, Year) impleted ceuse of death (Item 23a) (Type, Print) St. Lm 480 Baltimore 21201 Baltimore 685W. ichele 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

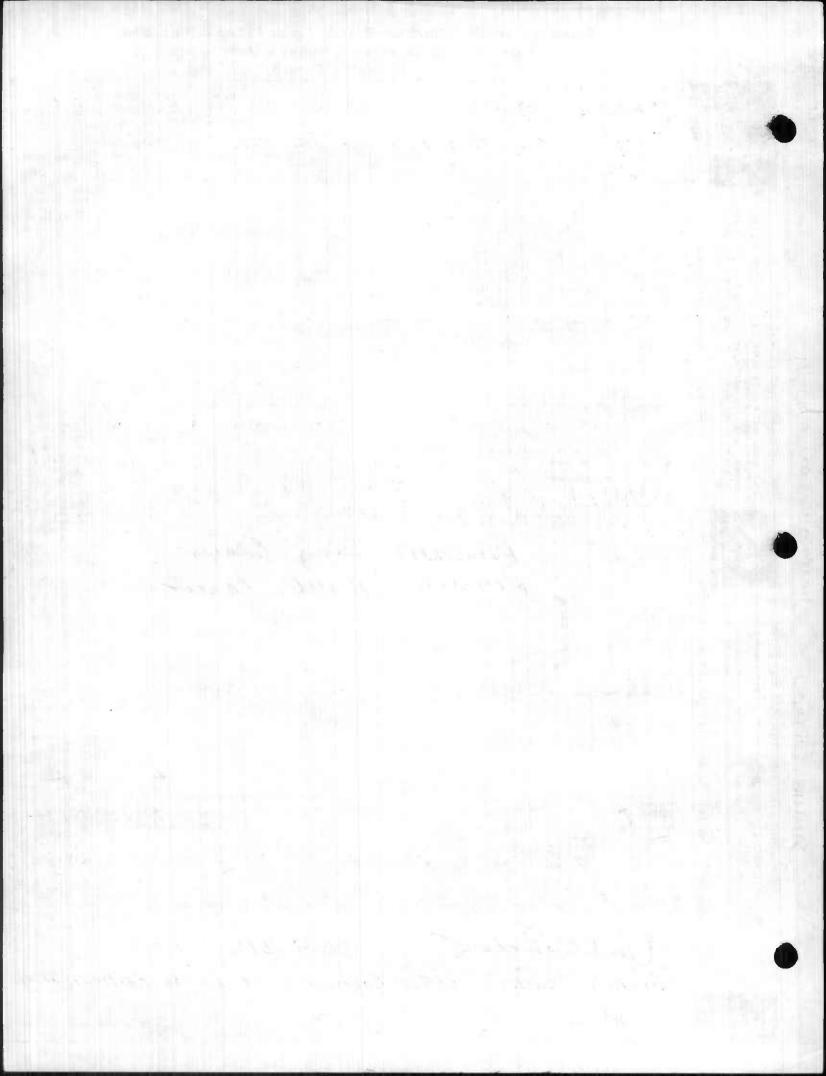
DHMH 16 Rev 6/95

Registrar

16,2000

ANUARY

JAN 2 1 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death SINGER Month Year **Physician** ALFRED .05 DAN. 2000 6 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA HOSPITAL DECURE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | (Month, Day, Year) | 133 BALTO If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10M 20F Months Days 218-28-239 Yrs. Usuel Residence of Decedent 10s. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No MD NIA BALTIMORE Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? MARY ANE 71416 U.S.A 3120 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status Bleck, Whita, etc. 1 Yes 2 DNo If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: white à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) EASTEIN STEELE ED. 12+1 Steele WORKER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SINGER Kernan JOSERH IRMA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO MO J. ANN 2815 21234 ROSALIE AUR HAUSER 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 DCremetion 3 ☐ Removel from Stete 119/2000 Green mount cemetery BAITO MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility HARTIEY MILLER 21. Signature of Funeral Service Licensee Funeral Home BHLTO MD 7527 HALFORD RD 21774 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Finel disease or condition resulting in deeth) Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or as a c 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably Driknown Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes ADINO 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the deeth certificate be executed Box 68760. Records, P.O. Division of Vital e Hospital or Attending 24 hours effer death. • Funeral Director: Aft

Funeral

Director

show

25e-f

8

Herra 23a

Pages 1 and 2 should be filed within 72 hours after mont of Health and Mental Hygiers, wound of Health and 27 is rearked other ban "natural; or its ury or other traumatic event, the Medical Exemples.

Department

Physician /Medical

Examiner

pue

the bunal-transit

65 for use

signed by the e

After this

filled in by

within 2

DHMH 16 Rev 6/95

8

edical

29a. Certifier

one)

(Check only

Baltimore, Maryland 21215-0020

the Manyland

State Registrar

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

29b. Signeture and title of certifier

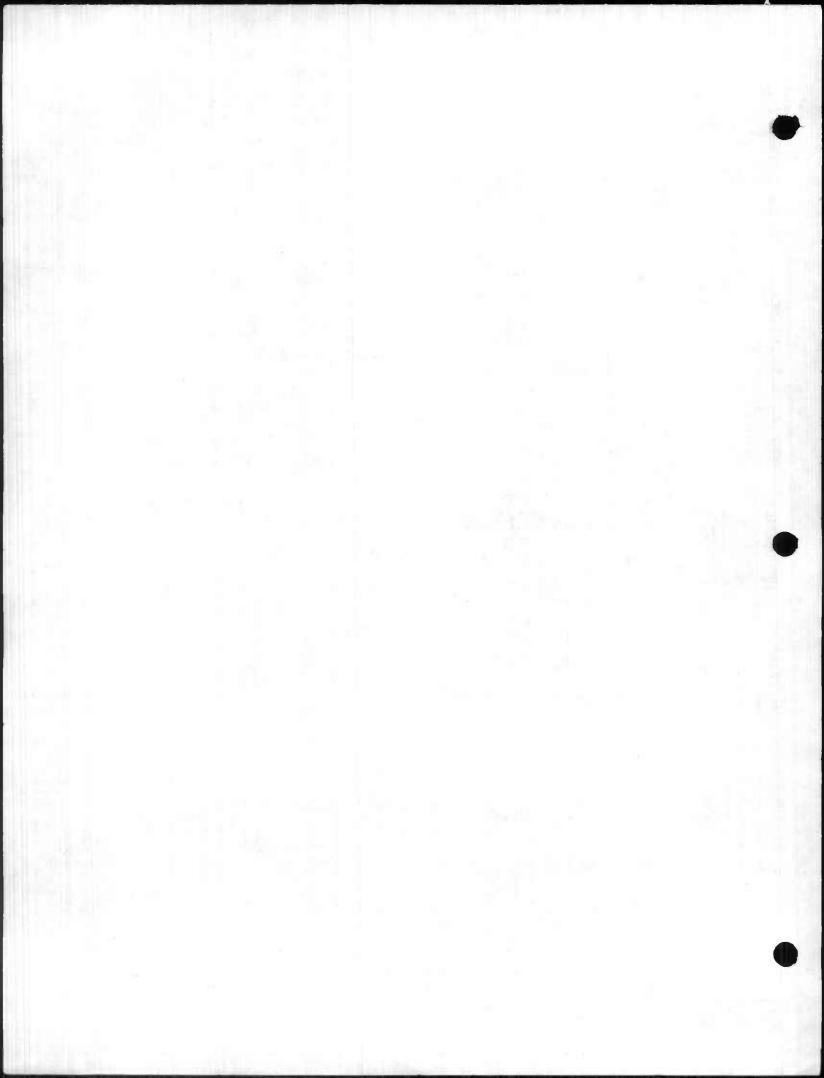
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

N-ELLOW -1AQA

31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

JAN 21

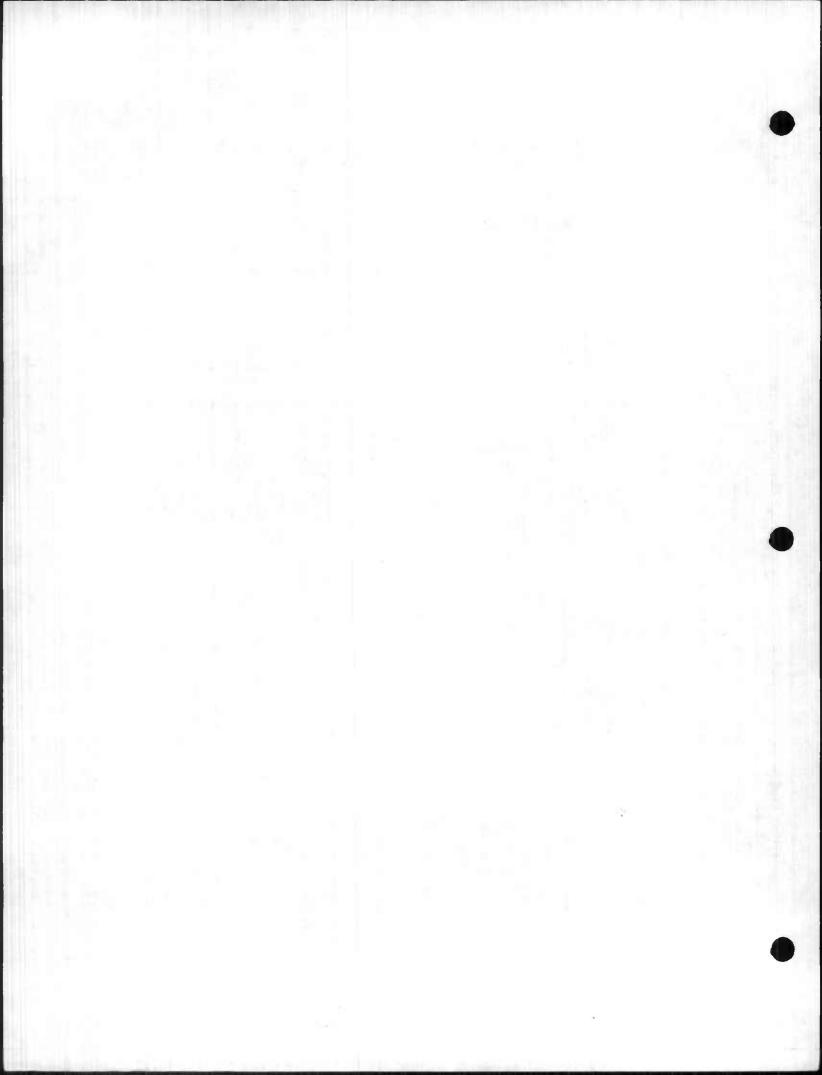


			State of Maryland / I	Certificate		F	leg. No.	01	408	
	sician edical	1. Decedent's Name (First, Middle, La Mary El12	aboth Stoull	eR		2. Date of Dea Month	Dey 2	Year 3.	Time of Death	
Funer Direct	_	011-18-1101	uris Hespic	(thdisy) If Under 1 Months E	Timor		4c. County Base 3 1909	Himor	State or Foreig	
anyland show of at	10	Usual Rasidence of Decedent 10a. Stete 10b. County	10c. City, Tow	n or Location		1			nside City Limit	
th with the Marylo 23a or 28a-f sho ust be notified at	lirecto	10e. Street and Number	HMORO I FUR	1	l 0g. Citizen of V		2,00			
liter dos	by Funeral Director	11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	1034 nt of Hispanic Origin? (Cuban, Mexican, Pue 100 Specify:	Specify Yes or No- rto Rican, etc.)		14. Rece - American Indian, Bieck, White, etc. Specify: White			
1 21215-0020 led within 72 hours at hygiens. her then 'naturet', or nt, the Medical Exami	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12)	Jucation de completed) College (1-4or 5+)	Decedent's Usual C (Give kind of work of life. DO NOT use if	done during most of w retired) NPLOYIO	1	16b. Kind of Bu Carvel St	Ice CE	leam	
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	To Be	17. Father's Name (First, Middle, Last)	Heeholl	U	18. Mothers No	leme (First, Middle, Maiden Sumeme)				
_ 2201		19g. Informant's Name/Reletionship (20a. Method of Disposition 1 Buriei 2 Cremetion 3	SON 6	D. Mailing Address (S Disposition (Name ny, cremetory or other	Street and Number or F OCHOR LA or place)	1. Baly	MORD 20c. Location	Md.	21234	
Baltimore poemt. Pages 1:s Department of the important: if from any injury or othe	1000	4 Donetion 5 Other (Specification of Fundamental Service Licenses)	I Wells	22. Neme end /	Address of Facility E Factord	vans Fu	Halif Treead Umore	Chapel Md	2/234	
Physicia /Medic	al er	23á-Penti. Ehfer the diseese, or com shock, or heart feiliure. List only Immediate Causa (Final diseese or condition resulting in deeth)	a. LYMPHOMA	consequence of):	or cyang, more as can ca	ac or respiretory an	esi,	Intai	roximata vai Between et and Death	
68760, tificate be executed gphysician and as the burial-transit		Sequentielly list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):			4			
ds, P.O. Box 6 ires that the death certific signed by the attending p d be detached for use as	/ Physician/M	Part II. Other algorificant conditions of	dontributing to death but not resulting le		23b. Did tobacco use contribute to the cause of 1 Yea 2 No 3 Probably 4X					
Record law reque has been be 2 should	Completed by					24a. Was a	med?	eveilable complet of death	utopsy findings e prior to lion of cause 1?	
- F # &	Be Co	25. Was case referred to medical			26. Place of D	eath (Check only or	72	1 🗆 Yas	2 □ No	
Phys Phys ral di	Certification: To 8	examiner? 1 Yes 2 X No 27. Menner of Death 1 X Naturel 5 Pending 2 Accidant investigation	T	□ Residence 6 X Other (Specify) HOSPICE escribe how injury occurred						
Division of or Attending after death. Director: After d in by the fune	ertific	3 Suicide 6 Could not be 4 Homicida datarmined	28e. Piece of Injury - At homa, fe building, etc. (Specify)	orm, street, fectory, o	ffice	28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural Rou	ite Number,	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai C	29a. Certifiar 1 Certifying Ph. (Check only one)	yalcian: To tha best of my knowledge ilner: On the basis of examination en end menner stated.	e, death occurred et t d/or investigation, in	the tima, data and place my opinion, deeth occ	e, and dua to tha c curred at the tima, c	ausa(s) and ma late and place, a	nner as stated	cause(s)	
To the within ?	Mec	29b. Signeture and filte of certifier		icense number	4	29d. Dete signed (Month, Day, Year)				
8		30. Name and address of person who of DR. TARIQ MAHMOO			TIMONIUM	, MD 2109)3			

DHMH 16 Rev 6/95

Registrar

January 17, 2000



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Year SCHAEFER January, 9:15 PM 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Yaar | tf Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Hours Days 1□M 2♥F Yrs. 80 215-12-3301 May 15, 1919 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yas 2 ☑ No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Rd. 21093 USA 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify: 3 ₩ Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemanlary/Secondary (0-12) Collega (1-4or 5+) Cashier 9 Food Fair 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Sumama) Harry Hartley Julia Mehling 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Jenny Schaefer/daughter 4123 Westview Rd. Baltimore, Md. 21218 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cematary, crematory or other place) Data 20c. Location - City or Town, Slata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal trom Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/19/00 Parkville, Md. Moreland Memorial Park 21. Signature of Euperal Service 22. Name and Address of Facility
Ruck Towson Funeral Home. Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enlar the disease, or complications that ceused the death. Do not anter the mode of dying, such es cerdiac or respiratory errest, shock, or heart tailure. List only one ceuse on each line. Approximate Intervel Between Onset and Death 245610X13-40X 1156252 Immediata Causa (Final disaasa or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediata causa. Enlar Underlying Causa (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Dua to (or as a consequence of): Pert II. Other eigniticant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Unknown chekin 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medicel 26. Placa ot Deeth (Check only ona) axaminar? Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar ot Death 28a. Data of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? Natural 5 Pending 1 Yas 2 No 2 Accident invastigation 6 Could not be datarmined 3 Sulcida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 4 Homicida Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Predict Examiner: On the basis of examination and/or investigation, in my coinion, deeth occurred at the time. 29a. Certifier

* Examiner Box 68760, Schaefer, Marie Division of Vital Records, P.O. Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

r than "natural", or hams 23s or the Medical Examiner must be

Director

Funeral

þ

Completed

Be 0

the Manyland

bours shar

Hed within 72 h Hygiena. Other than 'natu

permit. Pages 1 and 2 ahoud be fits.
Department of Health and Mental Hy, important: if them 27 is married other any injury or other

Physician

/Medical

attending physician and for use as the burial-transit

8 3

ate has been signed page 2 should be de

certificate

24 hours a

Within 2 To the

funeral

Physician/Medical

P

Completed

8

Certification: To

Medical

(Check only one)

29b. Signatura epo

3altimore, Maryland 21215-0020

or Attending Physician: after death.
Director: After this certifica

Registrar

DHMH 16 Rev 6/95

State

30. Name and address of person who complated ceusa of death (Item 23a) (Type, Print) FDUITE MAKHUDA 31. Data tiled (Month, Pay

6892

32. Registrar's Signatura

STF-LLA

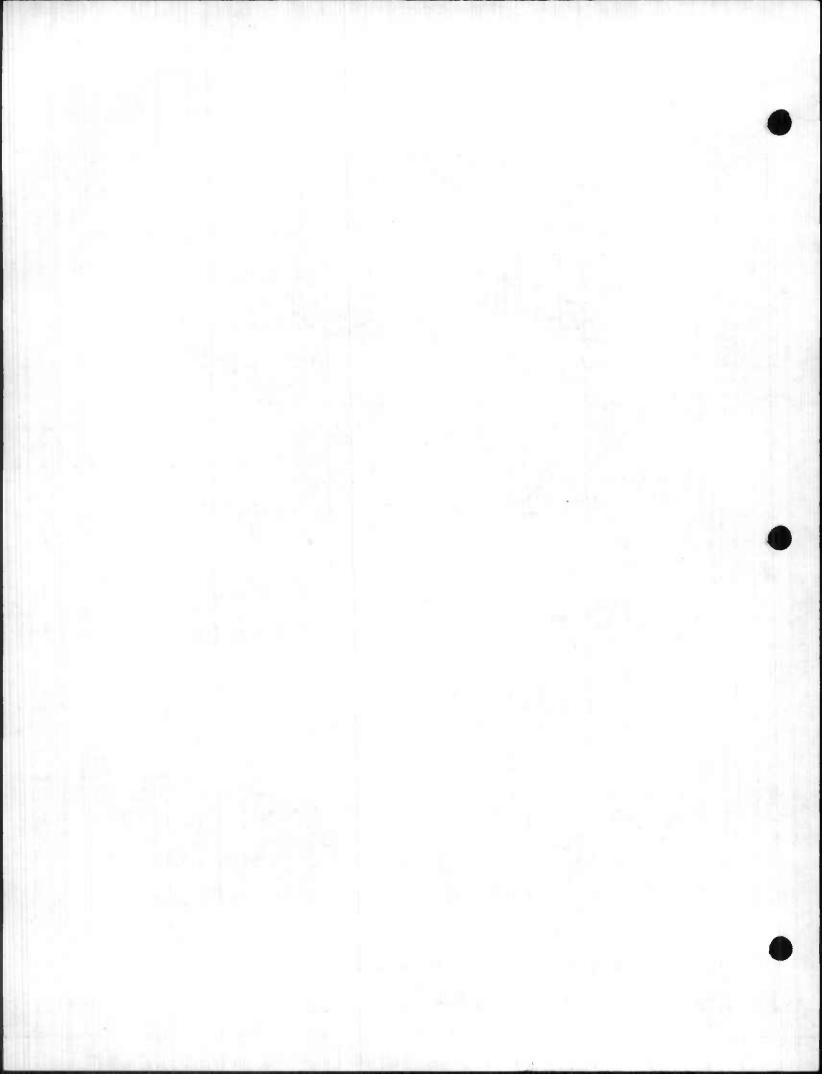
dicel Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licensa number

BACTO, MI

29d. Data signed (Month, Day, Year)

17-2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** Paul William Searfino 1:55 AM 2000 January /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rosedale If Under 24 Hrs. Baltimore Franklin Square Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours YEN 2□ F Months Days Min Yrs. 235-14-6116 1921 West Virginia Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Baltimore Middle River Maryland 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Altimeter Court 21220 U.S.A. Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Status 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 200 Married WWII 1 Yas 20No Specify: Specify: É 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Air Craft Mechanic/Assembler AeroSpace 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Joseph Serafino Ada Grimes 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Dorothy June Searfino (wife) 8 Altimeter Court, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other plece) 20c. Location - City or Town, Stete MBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 1/22/00 Bel Air, Maryland 21. Signature of Fungral-Strivice Licensee 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 23a 1941 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Approximate Intarval Between Onsat and Deeth Immediete Causa (Final disease or condition rasulting in death) Sepsis 12 Days Due to (or as a consequence of): Examine Urinary Tract Infection Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated sease) Dua to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospitel: 0 Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Monpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end place, end due to tha ceusa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura end titla of certifier 29d. Data signed (Month, Day, Year)

After this

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

or Attending

Funeral

Director

28a-f show

ъ

"natural", or Itams 23a

pemit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or

Physician /Medical

Examiner

physician and the burial-transit be asscuted

8 980

Box 68760,

P.O.

Division of Vital Records,

Reartino, Paul

State Registrar

DHMH 16 Rev 6/95

JAN 21 2000

Babaali,

Hossein Bab 31. Data filed (Month, Day, Year)

30. Nama end eddrass of person who completed cause of death (Item 23a) (Type, Print)

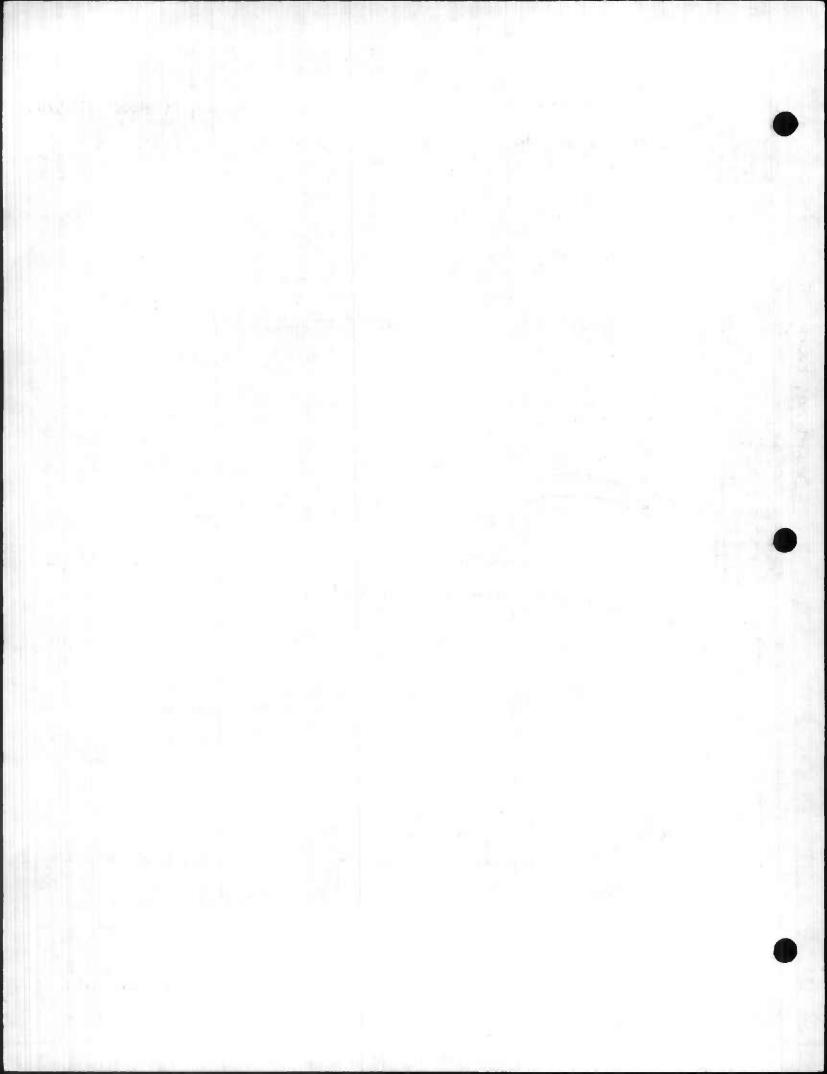
radi

32. Registrar's Signatura

MD 9000 Franklin Square Drive Baltimore, Maryland 21237

Jan. 19,2000

ORIGINAL



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

Obvedele	1. Decedent's Name (First, Middle, I	State of Maryla: #23 PART I,	2. Date of De Month		3. Time of Death					
Physician /Medical	James Wayne Sw		,		6, 2000 9:52 AM					
Examiner	4a Facility Name (If not institution, g 1259 SARGEANT	4b. City, Town, or Location of Death BALTIMORE 4c. County of Death N/A			of Death					
Funeral Director	215-78-3849	4 DAL ADE	M 2 F 7. Aga (In yrs. lest birthday) If Under 1 Year Months Days			Hours Min. 8. Date of Birth (Month, Day)		Birthplace (State or Foreign Country) Maryland		
R-s	Usual Residence of Decedent 10a. State 10b. County	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County 10c. City, Town or Location						10d. Inside City Limits		
or 28s-f short be notified at Director	VA N/	A Or	nancock					1 Yas 2□No		
be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?		
				2341			USA			
atural, or hame 234 cal Examiner must cal by Funeral		12. Was Decedent Ever in Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Dates:	1 ☐ Yas 2 Ø No If Yes, Give 1 ☐ Yas 2 Ø N			gin? (Specify Yas or N , Puarto Rican, etc.)		14. Race - American Indian, Black, Whita, atc. Specify: White		
		Education	cation 16a. Decedent's Usual Occ				16b. Kind of Bu	16b. Kind of Business/Industry		
Completed	(Specify only highest g	College (1-4or 5+)	life. DO NOT use retir			or working				
			Carpenter			de Name /First Afridali		truction		
o Be			22 22			r's Name (First, Middle net Marie (
ř	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street		or or Rural Route Numb		Stete, Zip Code)		
	Janet Ayers - m	other	808 W	. Ostend	St	Balto., Mo	21230			
0	20a. Method of Disposition	200	20b. Place of Disposition (Name of				Data 20s Lessting City of To			
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		altimore	Washing	ton Cr	1/ _{19/₀₀}	Laurel	. Md.		
any in	21. Signature of Funeral Service Lic	Jelen -		Name and Addre Pry L. Ka 250 Washi		Y		Howridge MP, Inc. Nd. 21075		
	23a. Part1, Eptar the disaase, or co shock, or heart failure. List on	inplications that caused tha d	aalh. Do not an	er the mode of dyl	ng, such as	cardiac or raspiratory	arrest,	Approximate Interval Between		
ician	/							Onset and Death		
lical iner	Immediate Cause (Final disease or condition rasulting in daath)	NARCUII	C INTOX:	ICATION	, , , , , , , , , , , , , , , , , , , 					
9		Due to	o (or as a conse	quence of):						
the buriel-transit	Sequentially list conditions	b	o (or as a consec	luence ot):				1		
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consequence ot):							
8	resulting in death) Last	C. Due to	Due to (or as a consequence of):							
clan	Det il Caberoles Misses and distance	0	and the size the	-4-4-2	in Dodd	O2h Dia	I tabasas was sar	half-the for the name of death?		
when can be the deeth. To the current Director: After this certificate has been signed by the attending photometric process to the funeral director, page 2 should be deteched for use as the decident of the funeral director. To Be Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not	ng to death but not resulting in the underlying cause given in Part I.				b. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Unknown			
			No.		s an autopsy iormed?	24b. Were autopsy lindings available prior to completion of causa of death?				
						1.28	Yes 2□No	1 Nes 2□ No		
	25. Was case referred to medical				26. Place	of Death (Check only	one)			
	examiner?	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatie	N 3L DOA		rsing Home 5 Res	idence KXOth	er (Specify) AT SCENE		
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	1 = 1 h = /(10)	UNKNOV	TAT Wo	ry at rk?) Yes 2\(\(\) 1	No UNKI				
	3 Suicide 6 Could not determine	building, etc. (Spe	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: PRIVATE DWELLING				28f. Location (Street and Number or Bural Route Number City or Town, State) 1259 SARGEANT ST. BALTIMORE, CITY, MD			
pletely fill edical	29a. Certifier 1 ☐ Certifying F	hysician: To the best of my l miner: On the basis of exam and manner stated.	knowledge, death Ination and/or in	h occurred at the ti vestigation, in my	me, date and opinion, deat	d place, and due to the th occurred at the time	e cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)		
N COUM	.29b. Signature and title of certifier	29c. Licen				9d. Date signed (Month, Dey, Year)				
/	Atush	& Vlac	LED, M	p 0.	C.M.E	.M.E JAN. 17, 2000				
/	30. Nama and address of person who Stephen S.	Radentz	111 Pen		, Balt	imore, Mar	cyland 21	.201		
State	31. Date filed (Month, Day, Year)	32. Registrar's Si		1 Ann	41					
Registrar	IAN 2.1	2000	The stand	· Kardy	10					

DHMH 16 Rev 6/95

ORIGINAL



00-02420-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene VALENCIA Amended Item#10e perFHG779 1/21 Cardio Cate of Death SMITH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** SMITH JANUARY 15, 2000 04:17 AM VALENCIA SHARON /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** 3823 FAIRVIEW AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours Min 1□ M 280€ Yrs. Director MARYLAND 214-84-6735 7, 1962 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete or 28a-f show 1X Yes 2 No Directo BALTIMORE CITY MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3823 Fairview Ave must be 238 U.S.A. 600 WOODSIDE ROAD 21208 Funeral Reca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) or flams 11. Merital Stetus filed within 72 hours after 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 1XNever Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: BLACK Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th grade ASSEMBLY LINER MANUFACURING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Mental 1 and 2 should be The market traumatics JUANITA A BROWNE CEPHUS SMITH SR 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health of If Item 27 600 Woodside Rd., Baltimore, Maryland 21208 Daronda F McDuffie/Niece Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Pages XXBurial 2 Cremetion 3 Removel from Stete ARBUTUS MEMORIAL PARK 1-22-00 BALTIMORE, MARYLAND 4 Donetion 5 Other (Specify) 22. Neme end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA lows 200 1206 W NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) SSTHMA Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diaese or Injury that initiated events resulting in death) Lest buriel-tran Due to (or as a consequenca of): Box 68760. Physician/Medicai Due to (or es a consequenca of): use as the for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.0. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 2 Records, þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Waa en eutopsy performed? Be Completed Yes 2 No 1 Dres 2 No of Vital or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1X Yes 2□ No this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Division 1 Neturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 D Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end mannar as stated. Medical completely (Check only one) *** Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. To the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number JANUARY 15, 2000 OCME

State Registrar

DHMH 16 Rsv 6/95

wile

JAN 2

HARADMOD

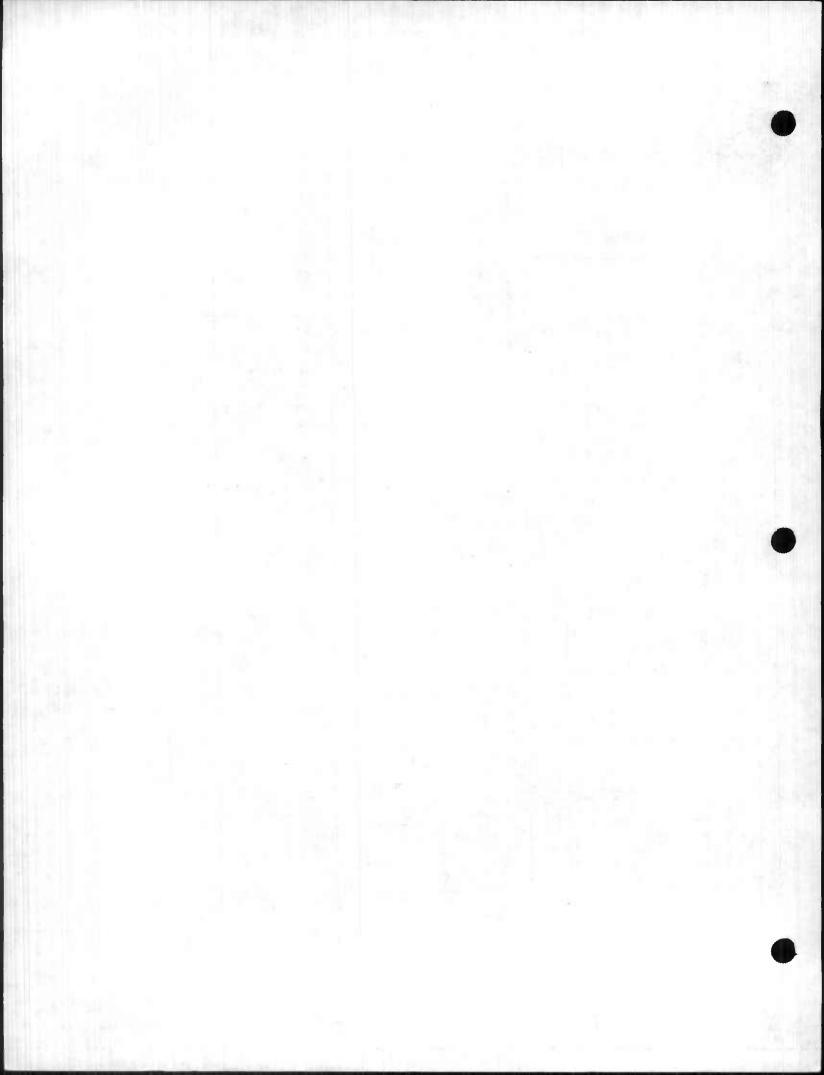
31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrac's Signeture

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Day Month Year HUDMAN SLAUGHTER 18 2000 January 1:pm 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death LAURELWOOD NURSING HOME ELKTON CECIL CO If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **XXM** 2□ F Yrs. 75 256-30-4438 OCTOBER 3, 24 ALABAMA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes XX No MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 LIBERTY STREET 21001 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces?

12. Wes Decedent Ever in U.S. Armed Forces?

12. Wes Decedent Ever in U.S. Armed Forces?

13. Ves 2 □ No If Yas, Giva Year or Dates: 33/46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ◯ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) GROOMING CERTIFIED BARBER 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTHA WHITE SLAUGHTER ALONZA SLAUGHTER 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Slaughter/Wife 50 Liberty Street, Aberdeen, Maryland 21001 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State 1-25-00 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funeral Se 22. Name and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Intervat Between Onset and Death Immediate Cause (Final 4 MONTHS disease or condition resulting in death) Carcinoma Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier

that the death certificate be executed Box 68760 P.O. Records, Vital Hospital or Attending Physician: Division of

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

show

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death

e filed within 72 hours after de if Hygiene.
Other than "natural", or frem

other 1

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avent pages.

Physician /Medical

Examiner

physician and s the burial-transit

signed I

this

Affer

• Funeral I

Examiner

Physician/Medical

p

Completed

Be

Certification: To

Medical

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

To the Fune completely f To the Vithin 2

Registrar

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MAKOUS, MO MONTE

Monte Mykons, MD

111

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

D-44783

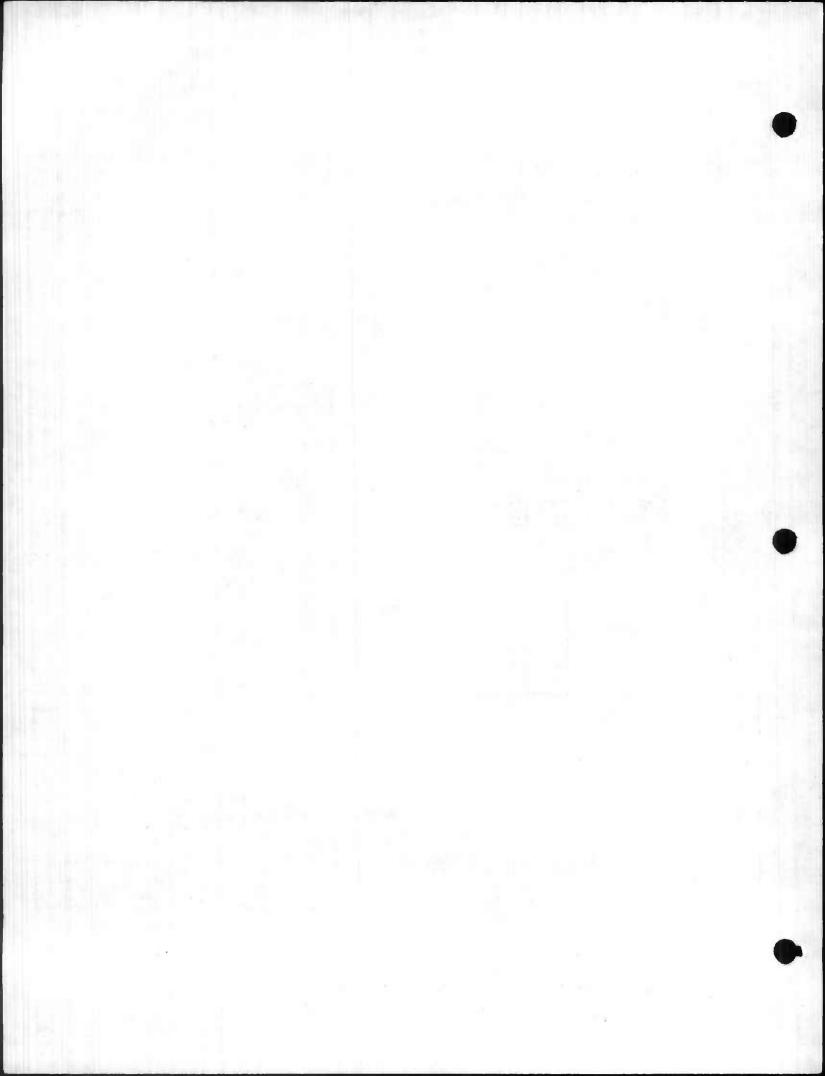
West High Street, ELKTON, MD 21924

January

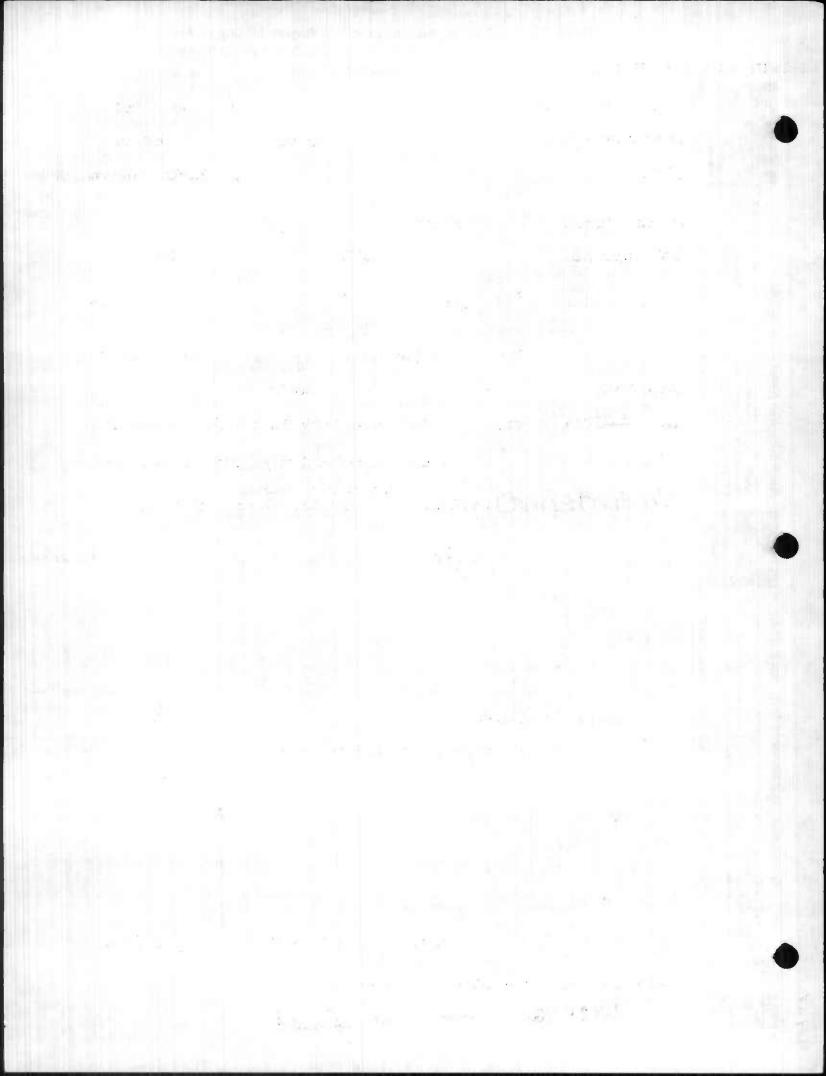
29d. Dete signed (Month, Day, Year)

19,2000

31. Dete filed (Month, Dey, Year) 32. Regist@r's Signeture JAN 2 1 2000 Seneva



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM # 19a PER FH G779 1/21/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harry Pentz Starkey 6:15 p.m. 13 2000 /Medical 4b. City, Town, or Location of Death 4e Fecliity Name (If not institution, give street and number) 4c. County of Death **Examiner** 22109 TANYARD ROAD CAROLINE Preston 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1 M 2 F **Funeral** Days Months Hours Yrs. 217 05 1126 83 Director April 21,1916 Baltimore, Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22109 Tanyard Road 21655 permit. Peges 1 and 2 should be filed within 72 hours after deeth 1. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s shy Injury or other traumatic event, the Modical Examiner must page. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supply Person City of Baltimore 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) George Starkey Emma Oritman 19a. Informant's Name/Belationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L Haser (Step daughter) 22109 Tanyard Road PO Box 98 Bethlehem, Maryland 21609 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park January 17,2000 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting In death) dementia **Examiner** physician and the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yaa 2 No 3 Probably 4 Unknown Kypertension à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy non insulin dependent disbetes melletus Completed 2 No 1 Yes 2 No 25. Was cese referred to medicel exeminer? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No Investigation deeth 2 Accident f or Attance efter deetl Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours e 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely f 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number D0047534 00 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WASIK ZAKI, M.D., 920 MARKET ST., DENTON, MD 31. Date filed (Month, Dey, Year) JAN 2 0 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 12, 2000 Madeline Sommer January 8:25 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) Aug. 17, 1905 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 M 2 F Maryland 219-30-2066 94 Yrs. Usual Rasidance of Decedent 10b. County 10a. Stata 10c. City, Town or Location 10d. Inside City Limits Baltimore Glen Arm 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4600 Long Green Road 21057 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc 1 Yas 2 No If Yes, Give Year or Dates: 1XXNevar Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Henry Hecker Susie Wahl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Celaine Montague/Daughter 4600 Long Green Road Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Moreland Mem. Park 1/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Fupe al Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final nermonie disaasa or condition rasulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementic 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? 2 No 1 Yas 20 No 1 Yes 25. Was casa refarred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

physician and the burial-transit certificate be axecuted

80

Completed

Be

Certification: To

edical

the signed by t

peed

this

Hospital or Attending Ph n 24 hours efter death.
 Funeral Director: After th

within 2

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

ahon

280-1

"natural", or flams 23a or

Hygiene.

permit. Pages 1 and 2 should be filled w Department of Health and Mantai Hygien Important: if them 27 is mentited other this any Injury or other two

72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

Be

MD

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Physician/Medicai ğ

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 40 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

1 Netural 2 Accidant 5 Pending invastigation 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

🕼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

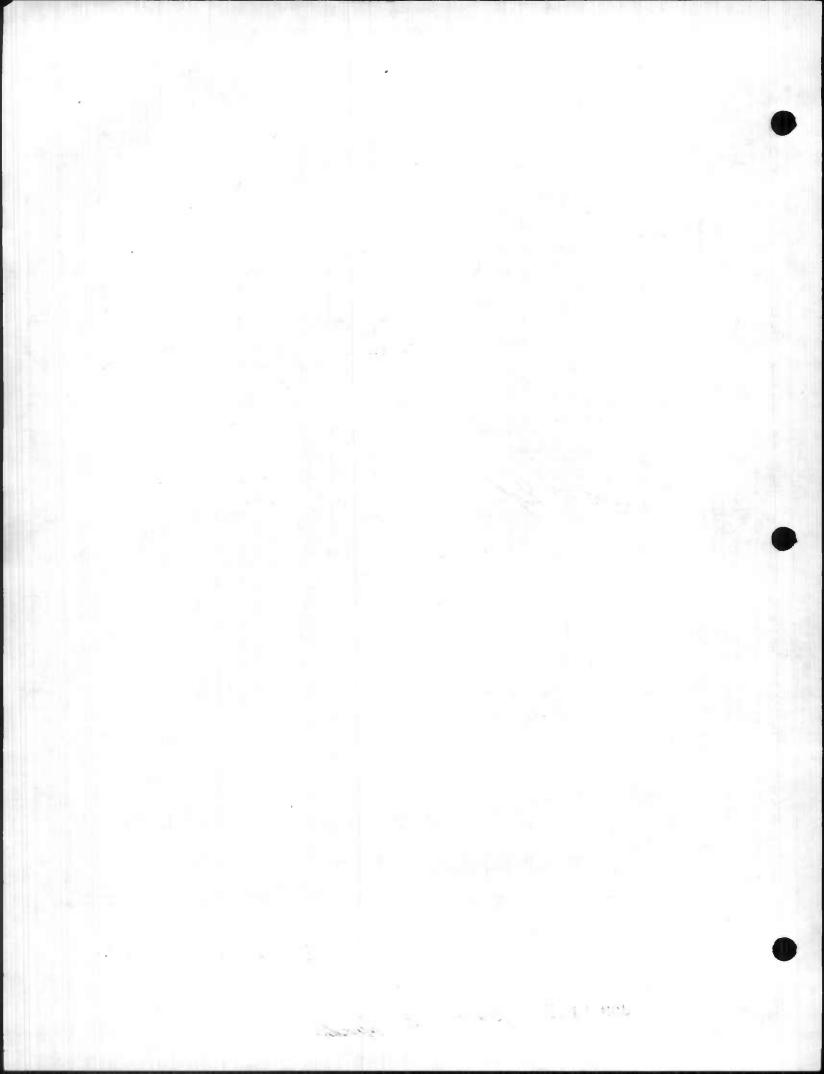
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifier

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Belline no 21230 Joh 1147 South
32. Registrar's Signature 1147 Henover 15.86

AN 2 1 2000 Lucy

State Registrar

DHMH 16 Rev 6/95



	00-02	89-	005 Please 1	ype or Print In BI					le.	1.0		
	STEPHEN		AMEND ITEMS: #23 P	State of Maryland ART i. 27 PER	Certificate of	Death			1 114	16		
	CHOMAS		1. Decedent's Name (First, Middle, Last,		oor in out o	2000	2. Date of Death	. No.		of Death		
	Physic /Medi		Stephen h	1. Thomas			JANUARY	17.20	Year 00 12:5	5P.M.		
	Examil		4e Facility Name (If not institution, give			4b. City, Town, or L		4c. County of		ZAJIAI.		
			FRANKLIN SQUARE H		et hinthday) If Under 1 Yea	ESSEX	100.100	BALTIMORE				
	* Funeral Director		5. Social Security Number 6. Sec 213-60-7234 15 Usuel Residence of Decedent	7. Age (In yrs. las	s Hours Min.	8. Date of Birth (Month, Day,)	1953	9. Birthplace (State Country) MOLRY Q	nd			
	ytand how		10a. State 10b. County	10c. City,	Town or Location				10d. Inside			
	s Ma		Md Harl	Rd Ja	RRettsville)				s 2 No		
	with the N s or 28a-4 be notifie	Funeral Director	10e. Street and Number	. II A'I.	10f. Zip Code	A C 1	109	. Citizen of W	hat Country?			
	w 23a must 2	era	11. Meritel Stelus	12. Wes Decedent Ever in U,S.	13 Was Decedent of	Hispanic Orlgin? (Sr	pecify Yes or No-	14. Race	- American Indian,			
020	urs after death with the Maryla al", or itams 23e or 28e4 sho Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu		Rican, etc.)		, White, etc.			
2-0	72 ho natur dical	peta	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occ (Give kind of work don	e during most of world	kina 16	b. Kind of Bus	iness/Industry			
21215-0020	Para Para	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	red) .	F	apkvil	Le Post O	office		
alad Y	Hygie than the	ပိ	17. Fether's Name (First, Middle, Last)	_	letter ca	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)			
lan	Mental Ked o	To Be	Ellsunoth.	Thomas		DOPI	8 B11	Sh				
Maryland	and No.		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street	et and Number or Ru	ral Route Number,	City or Town, S	State, Zip Code)			
ž	and a		JOAN May Thor	nas .	3855 Jak	cettsville	Pike, J.	appett	Sville, Md	21084		
Ore	T of H		20a. Method of Disposition 1 Burlel 2 Cremation 3 R	COL	ce of Disposition (Name of netery, cremetory or other p	(ece)	Jan. 20 20	c. Location - (City or Town, State	11		
Baltimore,	famen famen famen		4 Donation 5 Other (Specify) EVANS FUNERAL Chapal Lie 2000 FORIST Hell Md									
	MA PAR		21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Evans Funeral Chapel									
1	W		23e Part I Enter the disease or comple	L. Collections that caused the death	No not enter the mode of the	afford)	or respiratory arres	HIMORI	Approxim	1234		
1	Physician		23a. Part 1. Enter the disease, or complishock, or heart feilure. List only or	ne cause on each line.	Do not enter the mode or o	ying, such es cardiac	or respiratory arres	ι,	Interval B Onset and	etween		
	Physician /Medical		Immediate Cause (Final	HVDFRTFNS	SIVE ATHEROSC	FROTIC CA	DTOVASCIII	AR DIS	FASE			
P	Examiner		disease or condition resulting in death)		as a consequence of):	DENOTIO G	DIO (ADGO!	LAK DIC				
	D .E	xaminer							- 1			
,00	e asscuted sian and purial-transit	W	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or a	as a consequence of):			3	2 45			
87	rificate be awing physician as the buriel	edicai	that initiated events resulting in death) Last	Due to (or a	s e consequence of):							
X e	attending for use as	Me	C.	1								
m		clar	Part II Other elanificant conditions con-	stributing to death but not requit	ing in the underlying serves	niven in Part f	22h Did toh	9000 1188 000	bibute to the cause	City Limits es 2/4 No City Limits es 2/4 No		
O	the the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.					tobacco use contribute to the cause of death? Yes 2□ No 3⊠ Probably 4□ Unknown				
Ś	es the	by F										
ord	v require been si should I	ed					24a. Was an perform		24b. Were autops available prio	or to		
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be ax	law ras be	Completed	7						of death?	rcause		
	viclen: The lay certificate has irector, page 2	S					1,2 Yes	2□No	1 XYes 2	□ No		
	ystclan: The lav s certificate has director, page 2	9 Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)									
o		n: To	1 Syes 2 No 27. Manner of Death	28a. Date of Injury 2	28b. Time of 28c. In	4 Nursing ri	ome 5 Resident			mate mate se of death? Guide se of death?		
o	Attending or death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		ork? ☐ Yes 2 ☐ No						
<u> </u>	or Attending i after death. Director: After I in by the fune:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ral Di	S										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical		sician: To the best of my knowl ter: On the basis of examination						B(S)		
	o the o the omple	Med	29b. Signature and title of certifier	and manner staled.	29c. Lice	nse number	29	d. Date signed	(Month, Dey, Year))		
	F 3 F 8		Atanh	1 1/m	17.40	C.M.E.	77	NIT IN DAY	10 2000			
		}	30. Name and address of person who co	mpleted cause of death (Item 2		C.Pl.E.	JA	INDAKY	18,2000			
			Stenhen S. F.			Street,	Baltimore	, Mary	land 2120	1		

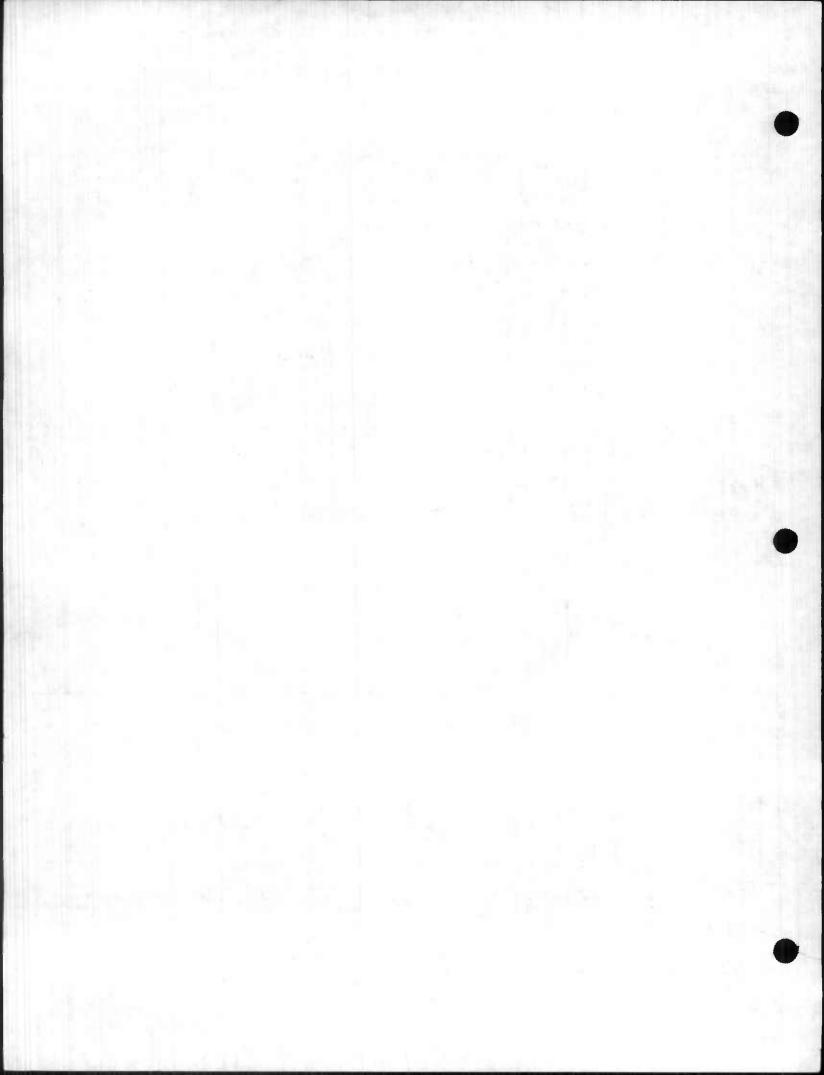
State
Registrar

State

JAN 2 1 2000

32/Registrar's Signature /

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Virginia Turner 8:00 PM Jan. 14 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manor Care Towson Towson Baltimore If Under 1 Year 6. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 1 M 2 TYF Yrs. 88 Sept. 14 1911 New Jersey 323-34-2484 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yas 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 E. Joppa Road 21286 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 L Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ryan Mary Windslow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Turner/Son 1652 Besley Road, Vienna, VA 22182 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/17/00 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens Timonium, MD 21. Signature of Funeral Service Lib 22. Name and Address of Facility Clary Lemmon Funeral Home Bryan 10 W. Padonia Rd., Timonium, MD 21093 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and a such sine. 23a, Part1. Enter the disease, or con shock, or heart failure. List only Approximete Intervel Between Onset and Death Immediate Cause (Final 5/2/5/2 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): 23b. Did tobacco usa contribute to the cause of death? 1 Yes 25No 3 Probably 4 Unknown 24b. Wera autopsy tindings available prior to completion of cause of deeth? 24e. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No 26. Placa of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner Physician/Medical 94 signed t Records, þ Completed Division of Vital or Attending Physician: Be Certification: To this After death. n 24 hours after death we Funeral Director: A pletely filled in by the f

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Berns 23a

8

'neturef.

hours after

filed within 72

Pages 1 and 2 should be next of Health and Merital

Department of Health an Important: If Item 27 is a any injury or other trau

Physician /Medical

Examiner

altimore, Maryland 21215-0020

Director

Funeral

Completed

99

Lo

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20€No 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 26b. Time of 1 Natural 5 Panding

25. Was case referred to medical examiner? Other: 45 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Deeth 28d. Describe how injury occurred 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suiclde 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one)

nide 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

Walter R. Welzant, M.D. 7600 Osler Dr., Suite 107, Towson, MD 21204-7705

29c. License number

29d. Date signed (Month, Day, Year)

JAN 2 1 2000 Deput 31. Date filed (Month, Day, Year)

State Registrar

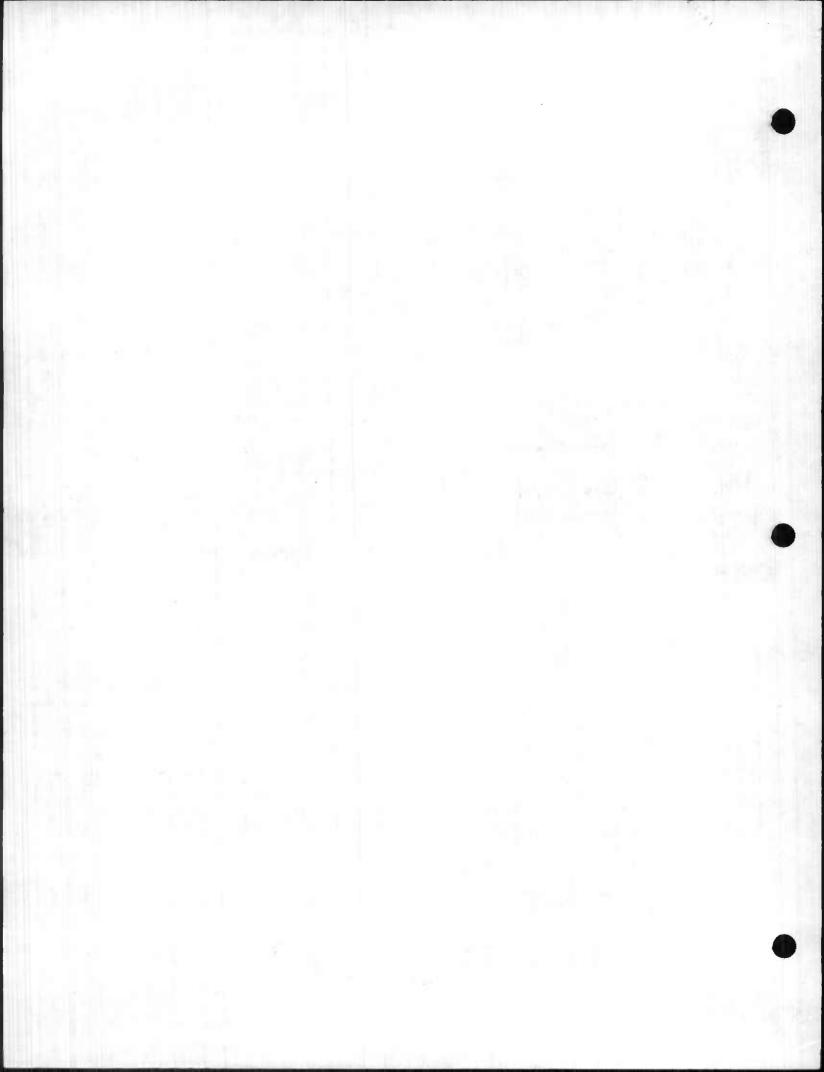
edical

29b. Signeture and title of certifier

DHMH 16 Rev 6/95

Hospital

To the Hosp within 24 ho To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:30 PM 17 2000 JAN. OPAL J. UPCHURCH /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6717 Garvey Rd. Baltimore County Baltimore 8. Date of Birth Month Day, Year) April 5, 1911 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 200 220-14-6662 88 Yrs. Director Maryland Usual Residence of Decedent The Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Baltimore Baltimore County 1 Yes 2 No Director 286. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21237 6717 Garvey Rd. USA Nerne 23a Funeral 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Bleck, White, etc. 72 hours after 1 Never Married 2 Merned 21215-0020 'natural', or 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 30XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry flied within 7 Hyglens. Other then "n Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 12th grade N/A altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lants if Nem 27 is marked oth lary or other traumatic even 88 Winfery Hoppers Kate Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. J. Kay Bartulis 6717 Garvey Rd. Baltimore, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Memorial Pk. 1-21-2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home 20 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical 30 min. Examine Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disease (o hears heimers Physician/Medical Dua to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Pressio of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitat: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Aesidence 8 Other (Specify) Certification: To the state of 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Division ne Hospital or Attanding in 24 hours after death. The Funeral Director: After pletaty filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) lon 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD

State Registrar

DHMH 16 Rev 6/95

JAN 2 1 2000

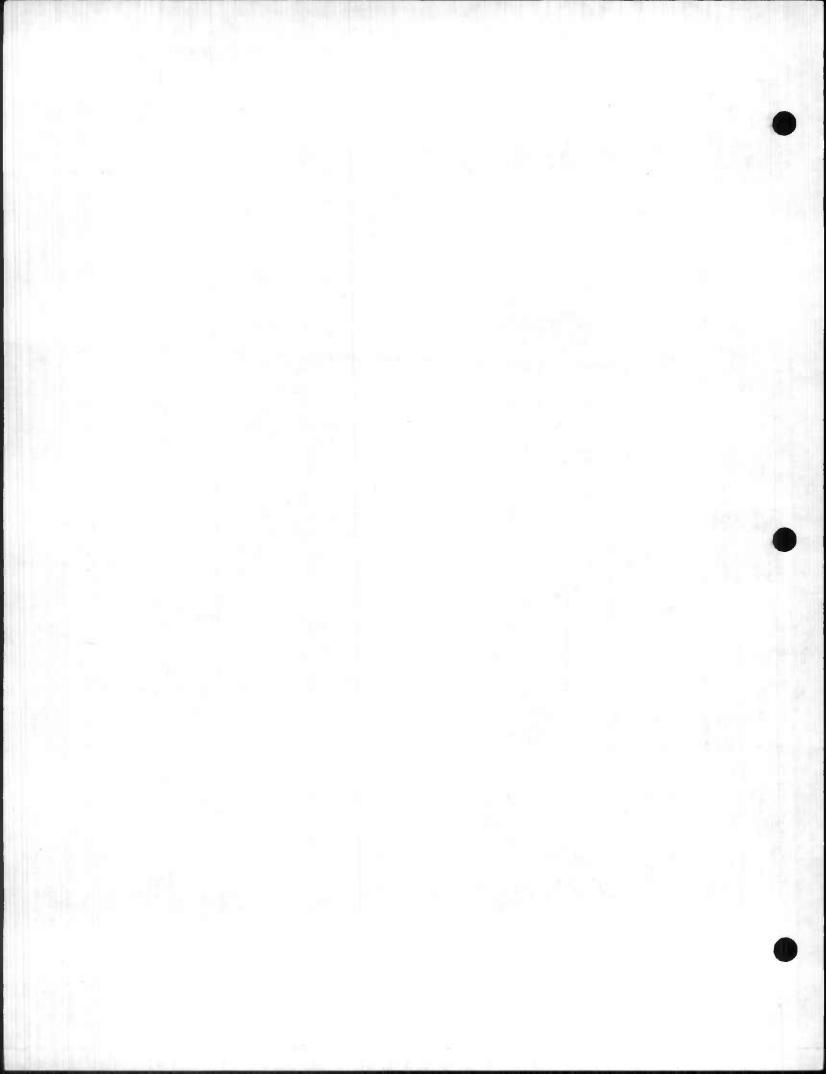
31. Data filed (Month, Day, Year)

McConnell MD

32. Registrar's Signature

Bersera B

Sporks sporks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 18,2000 WARREN JOSEPH VINCE 6:15A.M 4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Franklin Square Hospital edale Center OS ECIA If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Feb. 16 1948 7. Age (In yrs. last birthday) If Under 1 Vea 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Deys Months Hours 10 M 20 F 219-52-6749 51 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 50 No Director 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5673 Leiden Road 21206 USA Funeral or itsms 11 Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 25 No Specify: Specify White À 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) ince, Warren Plumbing & Heating Self-employed 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Michael E. Vince Sr. Irene Westgate 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Michael Vince Jr. / brother rportant: If Item 27 1250 Lower Glencoe Road Sparks Md. 21152 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State ö 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from Stete Oak Lawn Cemetery 1/21/2000 Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Pert 1. Enter the disease, or complicet cut that caused the deeth. Do not unter the mode of dying, such as cardiac or respiretory arrest, shock, or heer teilure. List only one datus on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Hepatic Encephalopath diseese or condition resulting in death) Examiner Examiner 10 Years urrhosis Hospital or Attending Physician: The law requires that the death certificate be associted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) P.O. Box 68760. Physician/Medical Due to (or es a consequence of) Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Division of Vital Records. should be d by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate director, Be 25. Wes case reterred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of Affer 5 Pending investigation 1 Netural after death. 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the causa(s) and menner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steled. Medical 29a. Certifier completely within 2. ş 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 0 M.D. Jankim January 18, 2000

State Registrar Jan

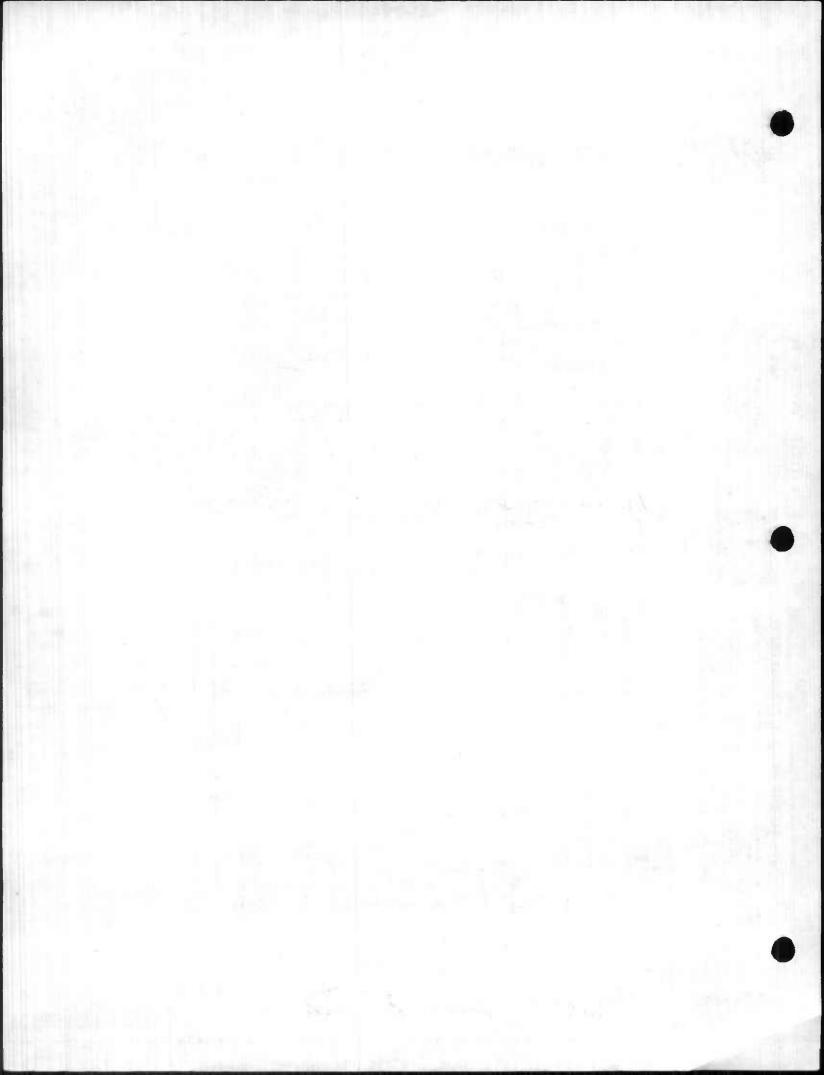
DHMH 16 Ray 6/95

Drive Baltimore, MD 21237

30. Name and address of person who completed cause of deeth (Item 23a) (Type Print)

9000 Franklin Square

222 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM: #23 PER MD G779 1-21-2000 WR. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Пау Month **Physician** Williams 01 15 2000 4:25PM Raymond /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Gilchrist Nursing Home Towson If Under 1 Yaar | If Under 24 Hrs. | Months Deys Hours Min. 5. Social Security Number 6. Sex 1 → M 2 → F 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) 05 02 Birthplaca (Stata or Foreign Country) **Funeral** Months 61 Director 238-56-5872 N.C Usual Residence of Dacedant 10a. Stata 10b. County 10c City Town or Location 10d. Inside City Limits 1X Yas 2 No Director Baltimore 28a-f MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 23a 21215 U.S.A. 3926 Dolfield Funeral Ave 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Meritel Stetus Black, Whita, atc. 1 Never Marriad 2 Married 8 21215-0020 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced filed within 72 hours Yaar or Datas Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Columbia Ass. of Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Land Management 10th grade na Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumame) 80 Pages 1 and 2 should be nant of Health and Mental Mary Jane Williams Joseph Bradley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if them 27 is or other tre Helen Williams-Wife 3926 Dolfield Ave, Baltimore Md altimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Buriel 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 1/22/2000 Woodlawn, Md 21. Signature of Europe Sarvice Licensee 22. Name end Address of Fecility March F/H West 21215 4300 Wabash Ave, Baltimore Md 23a/Paper Enter the disaesa, or comblications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart fellura. List only one cause on each line.

MULTIPLE MYELOMA Approximate tntervel Between Onset and Death **Physician** /Medical Immediata Causa (Final V 19 diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Lest and Dua to (or es a consequance of): The law requires that the death certificate be execu Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. RENAL, FAILURE 23b. Did tobacco use contribute to the cause of death? o s been signed by to should be detach 1 Yes 2 No 3 Probably 4 Unknown the Uti Division of Vital Records, Completed by 24b. Ware autopsy findings available prior to complation of cause of death? DIABETES MELLITUS 24a. Was an autopsy performed? has HYPERTENSION 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate al or Attending Physician: The safer death.

It Director: After this certificated in by the funeral director, pr 25. Was casa rafarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 28a. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. tnjury at Work? 5 Panding 1 DiNetural 2 Accident 1 Yas 2 No invastigation 6 Could not be datarmined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29b. Signeture and other of continue 29c. License number 29d. Dete signed (Month, Day, Year) no 30. Nama and addrass of person who completed cause of death (Item 23g) (Type, Print)

State Registrar 31. Deta filed (Month, Day, Year)

JAN 2 1 2000

A. Riley

GBMC (16701

32. Registrar's Signatura

Beggin Agency Agen

Sporks

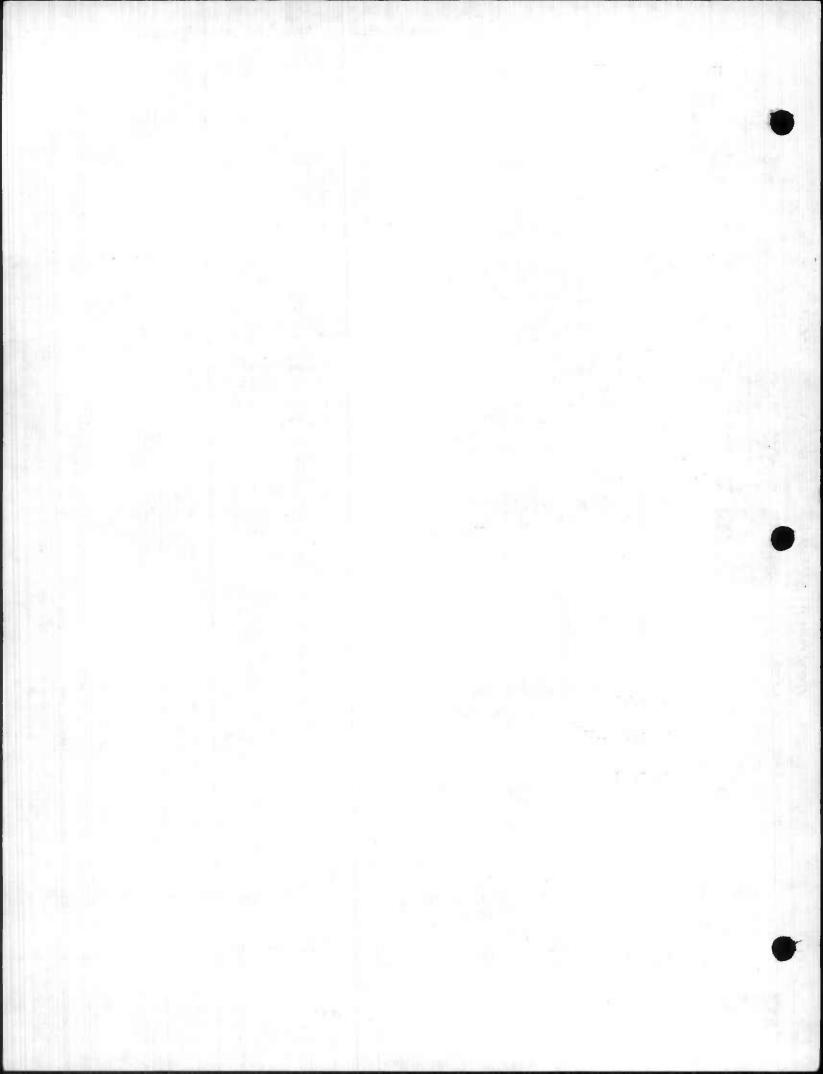
St. Balto. Md 21204

DHMH 16 Rsv 6/95

37

William

有限り うっつううべ



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ruth Wa 2000 00:40 January c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City Hospital Good Samaritan Baltimore 8. Date of Birth (Month, Day, Year) JWLY 30, 1923 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreig Country) Months Days Hours 1 M 20XF 197-12-6177 76 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9016 Tammy Road 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates; 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: specity: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Giblin Jane Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Walsh (daughter) 9016 Tammy Road, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 11/20/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident Atheroscierotic Condiavascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Rhoumatoid Arthritis 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tizer Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0402 Smuary 19, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.0. Division of Vital Records, To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funara

Physician

/Medical

Examiner

Director

Funeral

þ

Be

Funeral

Director

the

Baltimore, Maryland 21215-0020

tion 27 is marked other than "natural", or frama 23a or 28a-f ahow other traumatic avent, the Medical Examinat must be incurred as

flled within 7 Hyglene.

Permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item Z7 is marked other than any Injury or other traumatic avent, the Manages.

Physician

Ladinte

/Medical

ettending physician and for use es the burlel-transit

Examiner

Physician/Medicai

þ

Completed

Be

10

Certification:

this

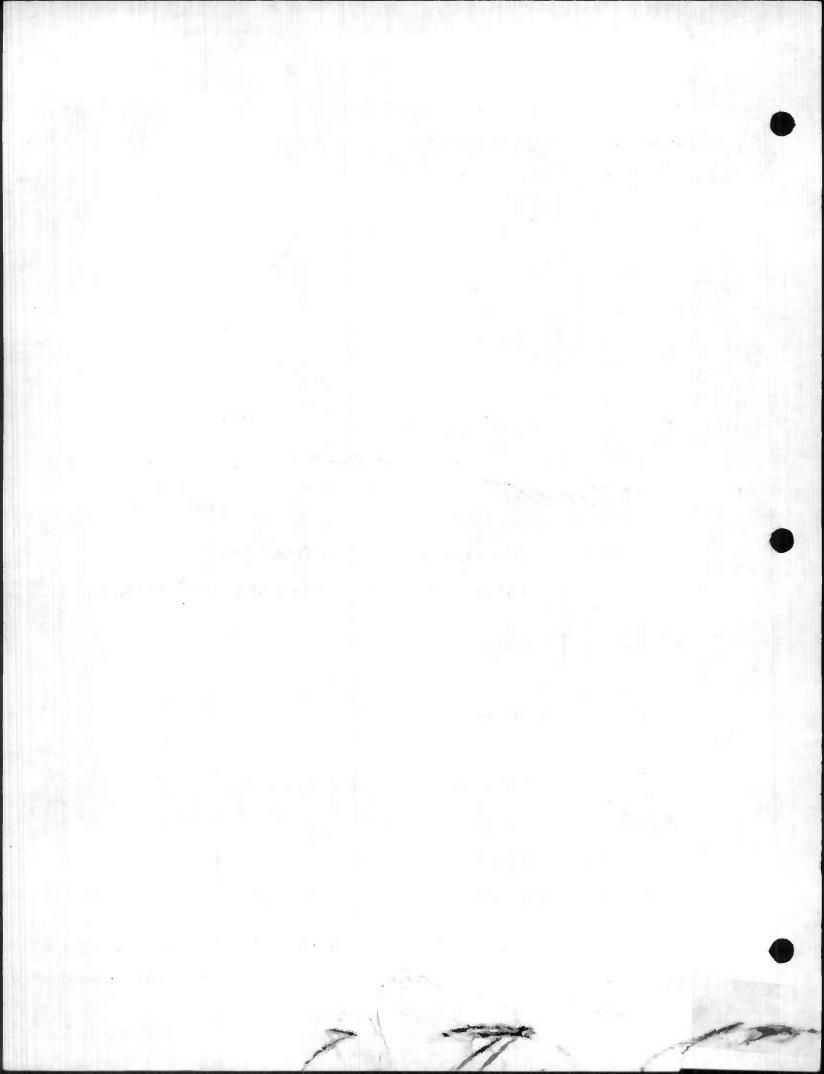
After t

State Registrar

WL16 Rev 395

31. Date filed (Month

5.WILSON MD, 560 Lock Roven Bld Baltmore M221259 32. Pagistrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1035 Month Year Raymond MOSKAL SR 2000 AN 17 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 9 Birthplece (State or Foreign Country) Hours 10 M 20 F Yes. 080-34-2994 Feb. 4,1942 New York Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Howard Jessup 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zio Code 20794 51 Maple VIllage, Box 432 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 Tyes 2 No If Yes, Give 1962-64 Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automobile Wholesaler Automobile 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Mabel Reichel Andrew J. Moskal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 51 Maple Village, Box 432, Jessup, MD 20794 Alma F. Moskal (Wife) 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, Stete Dete cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/20/00 Balto. Washington Crematory Laurel, MD 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Europeal Sel 5555 Twin Knolls Road, Columbia, MD 21045 23a. Pert 1. Enter the disease, or complications that caused shock, or heart feiture. List only one cause on each inwe death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

physician and the burlei-fransit The law requires that the deeth certificate be executed been signed by t should be detect

Box 68760.

P.O.

Division of Vitai Records.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23s or 28s-f show

a filed within 72 hours efter deeth vil Hygiene. Other than "natural", or flama 234

parmit. Pages 1 and 2 should be filt Department of Health and Mentel Hy Important: if Item 27 is marked oth eny Injury or other treumatic event abdes.

Physician /Medical

Examiner

aitimore, Maryland 21215-0020

Director

Funeral

Completed

Be

0

MD

with the Meryland

Examiner Physician/Medical þ Completed Hospital or Attending Physicien:
 124 hours after death.
 Funeral Director: After this carifical eleby filled in by the funeral director; g Be Certification: To

To the Hosp within 24 hos To the Fune completely fi

State Registrar

Medical

Clement B. Knight, M.D.

28a. Date of Injury (Month, Day Year)

29c. License number 411

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Dey, Year) 2000

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

11065 Litt otex ent 31. Date filed (Month, Day, Year)

JAN 2 1 2000

32. Registrar's Signature Siepers

Pan t wa

Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

5 Pending investigation

6 Could not be

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

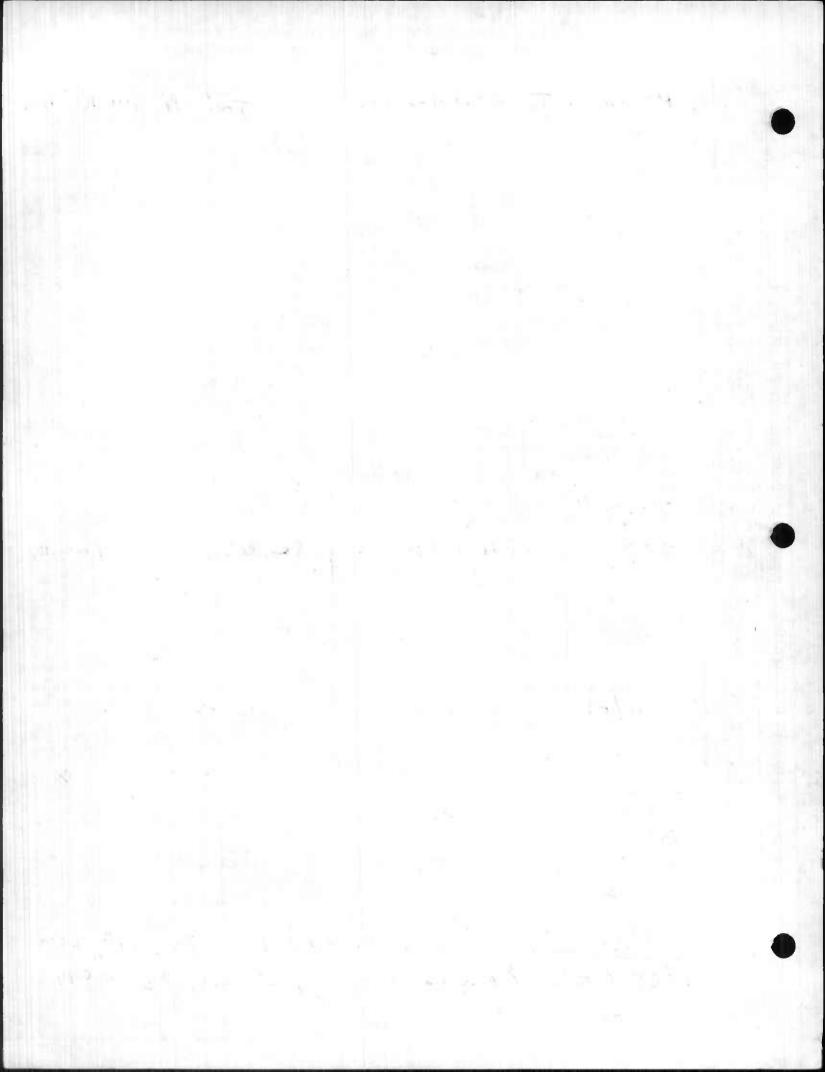
4 Homicide

(Check only one)

29b. Signature and title of certifier

28b. Time of Injury

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)



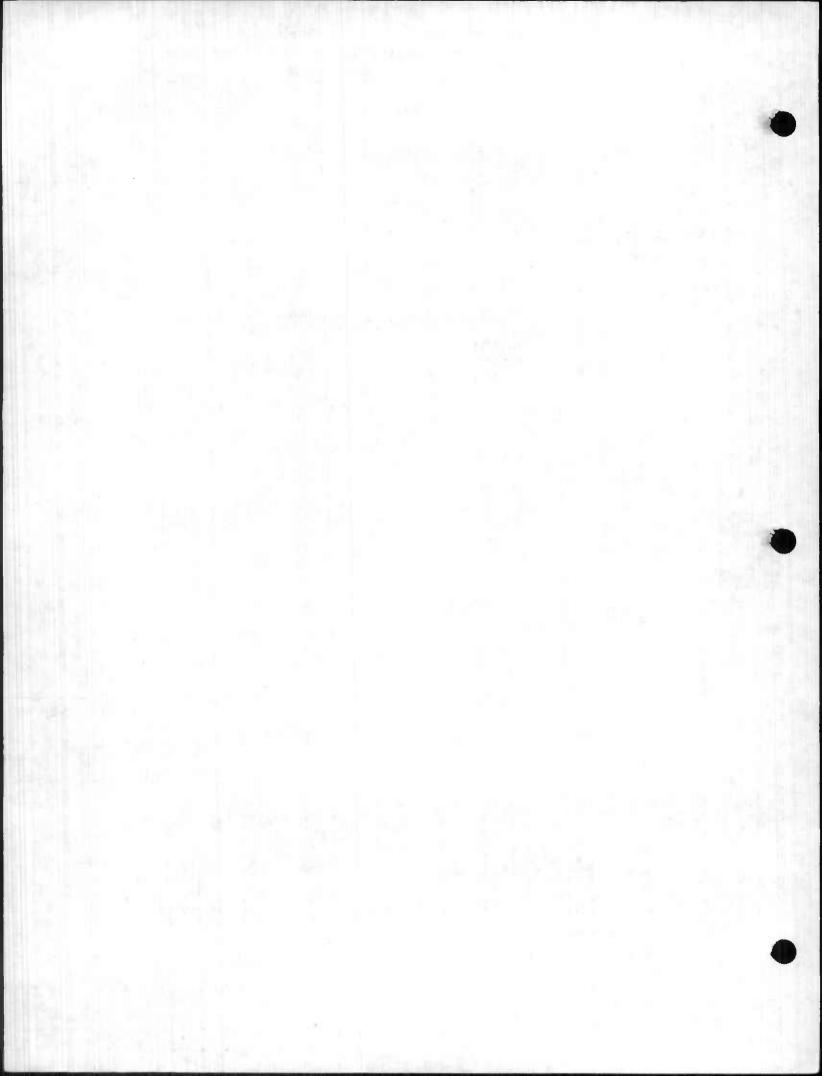
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Charles LIWilliams 23 Gertificate of Beath WR. PART PER MEO dent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 07, 25 January 2000 16:25 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 32 Enchanted Hills Rd Owings Mills
If Under 24 Hrs. 8 Date If Under 1 Year 5. Social Security Number 6. Sex 7. Age (in yrs. lest birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2□ F Months Days Hours Yrs. Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 25s-f sho the Medical Examiner must be notified at the Man No Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 14. Race 11. Marital Status Bleck, White, etc. 2 should be filed within 72 hours after and Mental Hygione. 1 ⊠Yes 2 □ No WYas, Give Year or Dates: 1 Never Married 2☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Ma DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or 19a. Informant's Name/Relationship (Type, Print) (Son opatiment of Health an important: if item 27 is n any injury or other 2005. , 2 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 20 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee Home Ker ra or HUR 23a. Part | Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failurs. List only one cause on each line. Approximata Interval Between Onsat and Death CARDIAC FIBROSIS Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burief-fransit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury and Due to (or as e consequence of) Box 68760. been signed by the attending physician should be detached for use as the burie that initiated events Due to (or as a consequence of) resulting in death) Last P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 45 kinknown þ Division of Vital Records. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 24a. Was an autopsy performed? 24b. Were autopsy findings avallable prior to completion of ceuse of daath? Completed Yas 2 No DE Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical 28. Place of Death (Check only one) Medical Certification: To Be Hospitel: Other: 4 Nursing HomeXxXXesidence 8 Other (Specify) XXXYes 2□ No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f 4 Homicide To the Hospital e within 24 hours a To the Funeral D Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

XXINEDICAL Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. January 08, 2000 30. Name and address of person impleted ceuse of deeth (Item 23a) (Type, Print) hutemo 111 Penn Street, Baltimore, Maryland 21201 Dennis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 910 Month eongra Wright January 07 2000 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death SECOURS GON HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. 8. Dete of Bi (Month, D 8. Dete of Birth (Month, Dey, Year) MAY 10, 1909 If Under 1 Year 9. Birthpleca (State or Foreign Country) VIRGINIA 5. Social Security Number 7. Age (In yrs. lest birthday) Deys 1 M 2 □ F 217-20-2950 Usual Residence of Decedent Yrs. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND 10e. Street end Number 10g. Oitizen of Whet Country? DUKELAND STREET 1501 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Dacedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 SNo Specify: Specify: BLACK 3. Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SCHOOL CUSTODIAN BALTO CO, PUBLIC SCHOOL 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WRIGHT PETE ELIZA BETH CUSTIS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) DEBBIE AND LAMONT THOMPSON COUSINS 6523 LEHWERT STREET, BALTIHORE MD. 21207 200 Method of Disposition (Neme of Dete 20c. Location City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Burial 2 Cremetion 3 Ramoval from State ZION CEMETERY 4 Donetion 5 Other (Specify) 01-24-00 LANSDOWNE, M.D. Filteral Service Licensee 22. Name end Address of Fecility BROWN JR. FUNERAL HOME 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heert feilure. List only one ceuse on each line. fmmediete Ceuse (Finel diseese or condition resulting in deeth) Aspiration pneumonis Dysphagga Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Cerebral resculer accident Dua to (or as e consequença of) Intected Sacral Alcer 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown Inteched of out vices 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Penpheral Masular disease

Physician /Medical Examiner

buriel-transit

the

been signed by the should be detach

certificate

After this

To the Hospital or Attending Pr within 24 hours effer death.

To the Funeral Director: After th completely filled in by the funeral

Be

Lo

and

P.O. Box 68760.

Records,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Director

ahow

7 is marked other than "natural", or items 23a or 28a-f ahov traumatic evant, the Modical Exoptiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tam 27 is marked other than "any Injury or other traumatic evant," in the

Pages 1

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

DIVERTICHIOSIS

1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

25. Wes case referred to medical exeminar? 1 Yes 2 No 27. Menner of Deeth 1 Neturel

2 Accident 3 ☐ Sulcide

4 Homleide

5 Pending Investigation 6 Could not be determined

Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 Yes

28d. Describe how Injury occurred

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end mannar statad.

29b. Signeture and titla of certifian

29c. Licansa number 030115 29d. Data signed (Month, Day, Year)

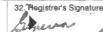
28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

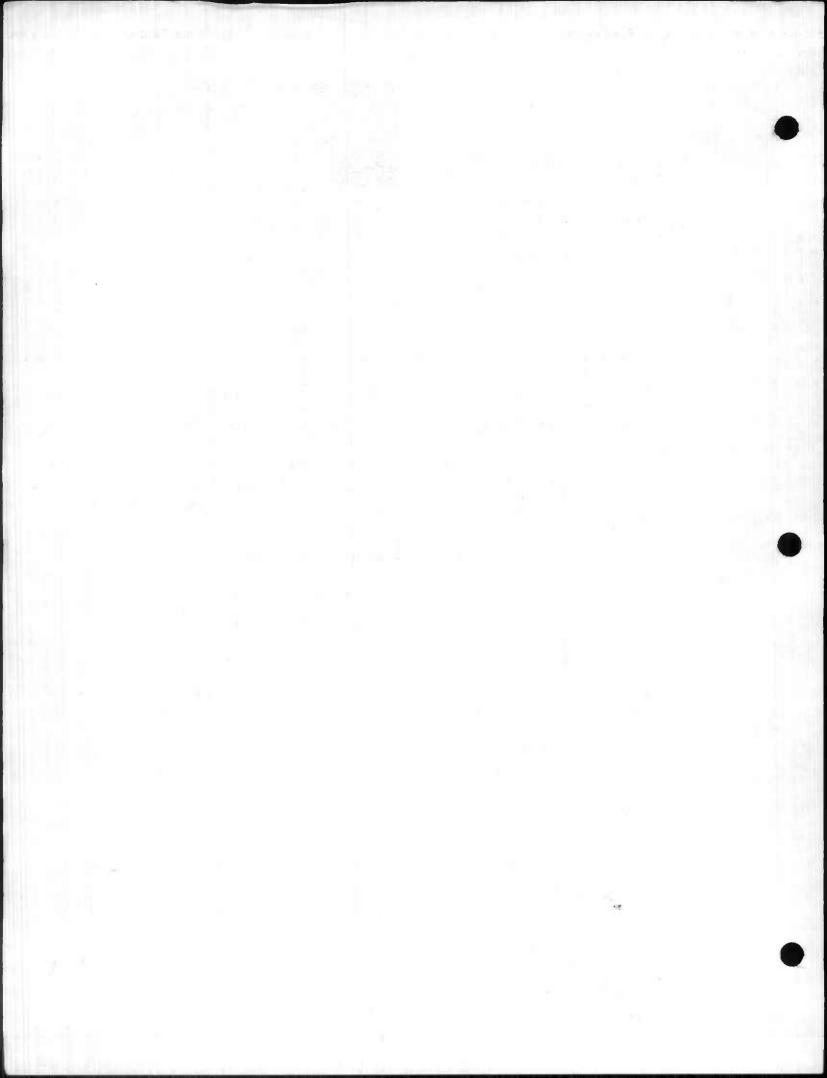
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2600 LIBERTY HEITS AVE BAIL, IMO 21215 hiokpehaimo 31. Dete filed (Month, Day, Year)

State Registrar

JAN 2 1 2000



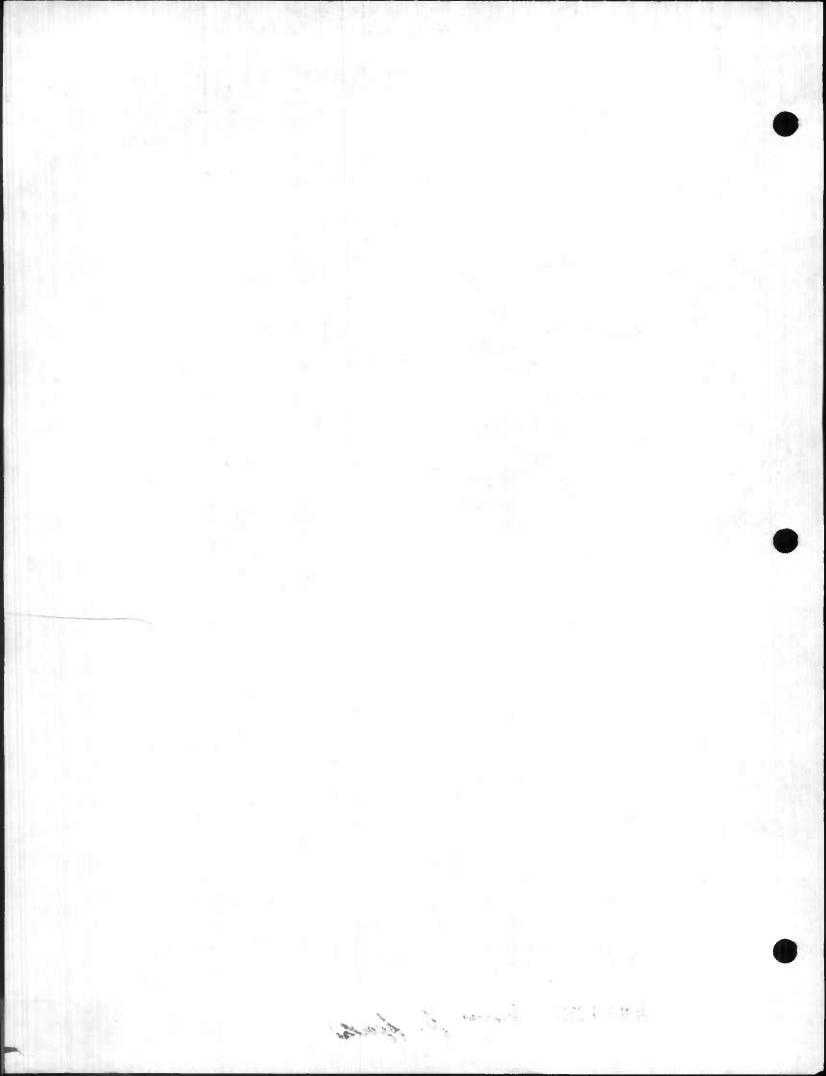


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

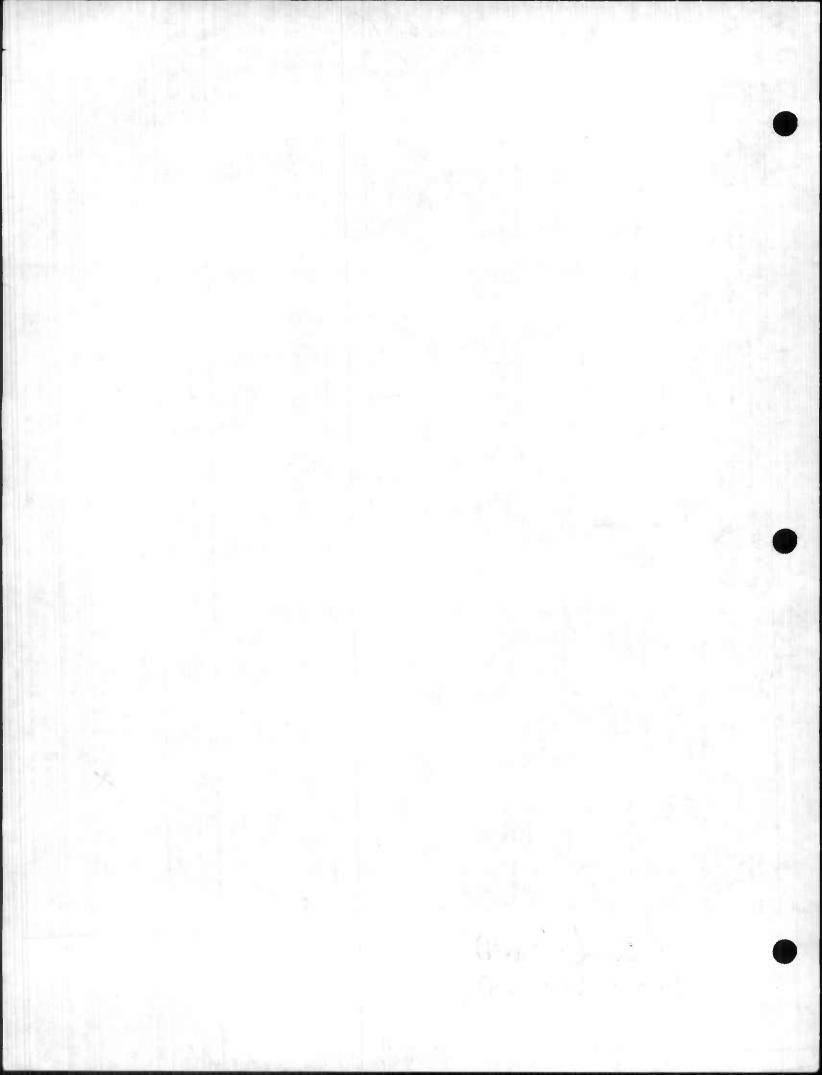
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Cecelia M. Waite 1. Decedent's Name (First, Middle, Last) 4:00 PM					Certificat	te of	Death			Reg. No.	J	14.60	
## S Facility Name of Foreign Annual Processor (a Section of Cartine of Cartine) of Cartine Of Cart	1. [Decedent's Name (First, Midd	le, Last)						2. Date of De	ath		3. Time of Death	
Table Name of not such town, pive stored and number) NATOX CAXC TOWSON South Security Number Local South Security Name of Local S	Physician	Cecelia M Wa	ite									4.00 PM	
MAINOY CATE TOWSON S. Book Scourly Number S. Book Scourly Number S. Book Scourly Number S. Book Scourly Number S. Book Scourly S. Double Residence of Devotions 100 Corry 100 Corry	nvieurcai			ar)		-	4b City To	own or Lo				4.00 FM	
5. Seed Security Furniture 215-12-9545 Usual Presidence of Decedent 106. Date 11 The County 106. City Town or Location Baltimore 107. The County 108. Seed of Decedent 108. Seed of Member 11 The County 109. The County 100. The Decedent Seed of Decedent 11 The County 100. The Decedent Seed of Decedent 11 The County 100. The Decedent Seed of Decedent 11 The County 11 The Seed of Decedent Seed of	niner	Tabling (17 Hot Mothers	ii, giro stroot and itollice	,,,				,		vo. ooung	y or oour		
215-12-9545 TOW 28E 78 Yrs Months Days Hours Min North Days Year Country TOW 29D TOW 200 TOW 200						- 53	Tows	on		Balti	more		
215-12-9545 MD Decident Too. Conty Too. City, Torn or Location Too. City Conty Too. City, Torn or Location Too. Street and Number Too. County Too. City, Torn or Location Too. Street and Number Too. County Too. City, Torn or Location Too. Street and Number Too. County Too. City Torn or Location Too. Street and Number Too. County Too. Count	5. 8	Social Security Number			Months				8. Date of Birt	h v. Year)	9. Birthp	lace (State or Foreign	
Table The Service of Development Table	2	15-12-9545	1UM 281F	78	rs.	,-							
ND. Baltimore 100. Zip Code 100. Citizen of What Country? 100. Citizen of What Count	Usi	ual Residence of Decedent											
12. 20.	100	State 10b. County		10c. City, Town	or Location						1	0d. fnside City Limits	
128 Coleman Ave. 12 Wes Decoded Four in U.S. 13 Wes Decoded of Register Origin? (Specify Yas or No. 11 Agrand State) 10 West Married 2 Memind 3 Memi				Dollain.							-	1⊠Yes 2□No	
4128 Coleman Ave. 12 Was Decoded Ever in U.S. 13 Was Decoded in Ever in U.S. 13 Was Decoded in Ever in U.S. 14 Was Decoded in Ever in U.S. 15 Was Decoded in Ever in U.S. 16 Res. American Indian, 17 Was One 20 Was Specify Class. 16 Res. American Indian, 18 Was Decoded in Ever in U.S. 18 Was Decoded in U.S. 1	100			Daiti		0.1							
13. Was Decodering of Hispanic Origin? (Seed) Yea or No. 12. Was Decodering Fair N.S. 13. Was Decodering Origin? (Seed) Yea or No. 13. Was Decodering Origin. (Seed) Yea or No. 14. Was Decodering Origin.	106	a. Street and Number			101. 21	p Code				Tog. Citizen or	what Coun	try ?	
11 Mean Married 12 Mean Comment 13 Mean Comment 13 Mean Comment 14 Mean Comment 14 Mean Comment 15 Mean Comment 15 Mean Comment 16 Mean Co		4128 Coleman	Ave.		2	1213				IISA			
Ones Married Ones Married Ones of Ones	11.	Marital Status			13. Was Dece	dent of I	lispanic Ori	igin? (Spe	ecity Yas or No				
Specified Science Spec		1 Nevar Married 2 Mer							ricall, etc.)	Black, Writta, etc.			
Secretary Secr		3 ₩ Widowed 4 Divorced	If Yes, Give 4	S:	1 LJ Yes	2 № No	Specify:			Specif		+0	
Comparing the production of	-	15 Deceder	t's Education	160	Decedent's Heu	al Occur	nation	_		16h Kind of B			
Secretary Secr		(Specify only highe	st grede completed)	164.	(Giva kind of wo	ork dona	during mos	t of worki	ing	TOD. INITIO OF B	Jan Gasanic	Justiny	
17. Fahar's Name (First, Middle, Last) John Bernard Schmedes John Bernard Schmedes John Bernard Schmedes As Pale Button (daughter) 20a. Membor of Disposition 18 Buttal SQCremation 3 Themoval from State 4 Docation 5 Tohnes (Speech) Hilltop Service Corp. 18. Sphajire of Funatal Service Lampses Dennife Controlled of	E		College (1-4d	or 5+)	me. DUNUTU	130 FB(IFB)	0)						
John Bernard Schmedes 196. Mailing Address (Street and Number or Paral Route Number, City or Town, State, 26 Code)		12 7		Se	cretary					Finan	ce		
196. Mailing Address (Street and Number or Pural Route Number. City or Town, State, Zip Code) A. Dale Button (daughter) 2.203. CloverGale Drive Fallston, MD. 21047 A. Dale Button (daughter) 2.203. Elevated Disposition 1. Burlar 2 (Clorenation 3 Removal tron State 40 ponation 50 librer (Speciely) 2.1 Signature of Funeral Service Liverges Detript C. Carrol 122. Name and Address of Facility Ruck Towson Funeral Home, Inc. 2.2 Part 1 Ende me disease, or complications filling caused the death. Do The easter the mode of dyng, such as cardiac or respiratory errest. 2.2 Part 1 Ende me disease, or complications filling caused fine death. Do The easter the mode of dyng, such as cardiac or respiratory errest. 2.2 Part 1 Ende me disease, or complications filling caused fine death. Do The easter the mode of dyng, such as cardiac or respiratory errest. 2.2 Part 1 Ende me disease, or complications filling caused fine death. Do The easter the mode of dyng, such as cardiac or respiratory errest. 2.2 Part 1 Ende me disease, or complications filling caused fine death. Do The easter the mode of dyng, such as cardiac or respiratory errest. 2.2 Part 2 Ende of Death (Charles or Institution) one cause on each line. 2.3 Part 3 Ende of Death (Charles or Institution) one cause on each line. 2.4 Ende of Death (Charles or Institution) one cause on each line. 2.5 Wes cases referred to medical or respiratory errest. 2.6 Place of Death (Charles only one) 2.7 Endough (Death or Institution) one cause on each line. 2.8 Place of Death (Charles only one) 2.8 Part 2 Endo of Death (Charles only one) 2.8 Part 2 Endo of Death (Charles only one) 2.8 Part 2 Endo of Death (Charles only one) 2.8 Part 2 Endo of Death (Charles only one) 2.8 Death (Charles only one)	17.	Fathar's Name (First, Middle,	Last)				18. Mothe	er's Name	me (First, Middle, Maiden Surname)				
19th Informati's Name/Reletionship (Type, Pirri) 19th Maling Address (Street and Number or Rural Rouse Number: City or Town, State), Zip Code) 22.03 CloverRale Drive Fallston, MD, 21.047 21.047 22.04 22.05 History of other piece) Date 20. Location - City or Town, State 20. Entered of Deposition (Name of Computer Science) Date 20. Location - City or Town, State 20. Entered of Deposition (Name of Computer Science) Date 20. Location - City or Town, State 20. Entered of Deposition (Name of Computer Science) Date 20. Location - City or Town, State 20. Entered Deposition (Name of Computer Science) Date 20. Location - City or Town, State 20. Entered Deposition 20. Entered Dep		John Bornard	Cabmada -				Mar	garet	et May Hoidorman				
A. Dale Button (daughter) 20. Newdood of Disposition 1 Burla 2 (Cormation of State 4 Contains (Specify) 11 Burla 2 (Cormation of State 4 Contains (Specify) 12 I Software of Fundament (Specify) 13 I Software of Fundament (Specify) 14 I Software of Fundament (Specify) 15 Software of Fundament (Specify) 16 I Software of Fundament (Specify) 17 I Software of Fundament (Specify) 18 I Software of Fundament (Specify) 19 I Software of Fundament (Specify) 19 I Software of Fundament (Specify) 10 Software of Fundament (Specify) 11 Software of Fundament (Specify) 12 Software of Fundament (Specify) 13 Software of Fundament (Specify) 14 Software of Fundament (Specify) 15 Software of Fundament (Specify) 16 Software of Fundament (Specify) 17 Software of Fundament (Specify) 18 Software of Fundament (Specify) 19 Software of Fundament (Specify) 20 Software of Fundament (Specify) 21 Software of Fundament (Specify) 22 Software of Fundament (Specify) 23 Software of Fundament (Specify) 24 Software of Fundament (Specify) 25 Software of Fundament (Specify) 26 Software of Fundament (Specify) 27 Software of Fundament (Specify) 28 Software of Fundament (Specify) 29 Software of Fundament (Specif	10			105	Mailing Address	s (Street					-	Coda)	
20a. Method of Disposition Clark of Exposition Clark of Debt 20c. Location - City or Town, State Clark of Control C			imp (1)po, 1 mil)										
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I. Dust to for as a consequence of: Dust t	-		(daughter)				ale D	rive					
Aprovement Carrol 122. Name and Address of Ferility Ruck Towson MD. 212.04	20a		2 Demonstran Ste	comotor	Disposition (Ne	me of other ple	ce)	į	Date	20c. Location	- City or To	wn, Stata	
23. Signature of Funaral Service Lamps Dennis C. Carro 122. Name and Address of Facility Ruck Towson, MD. 21204 23a. Part Leffat the disease, or complications that caused the death. Do Release of the Part Leffat the desires of heart fellule. List only one cause on each line. 1050 York Rd. Towson, MD. 21204 23a. Part Leffat the desease, or complications that caused the death. Do Release of the Part Leffat the desire of heart fellule. List only one cause on each line. 1050 York Rd. Towson, MD. 21204 Approximate and Death fellule. List only one cause on each line. 1050 York Rd. Towson, MD. 21204 25a. Part Leffat the desease, or complications that caused the death. Do Release of the Part Left on the Carro of C					on Coru	ico	Cown	17	1201200	0 =			
232. Part I, Effat the disease, or complications that caused the death. Do the exterior the mode of dying, such as cardiac or respiratory errest. Approximately intervel between check of heart failure. List only one cause on each sine. Immediate Cause (Final disease or conditions, intervel between check of heart failure). List only one cause on each sine. Immediate Cause (Final disease or conditions, intervel between check of heart failure). Due to (or as a consequence of): Duylo (or as a consequence of): 1 Yee 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yee 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 24a. Was an autopsy performed? 25b. Wee case referryd to medical examiner? 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 25c. Wee case referryd to medical examiner? 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown - LX LL SSI-LL AV + I CO & Jule + I/h 1 Yes 2 No 3 Probably 4&Unknown -	21		CONTRACTOR	C. Carro	122 Nama a	nd Addre	ess of Facili	tv_ a	718/200	U TOWS	on, M	D.	
Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It.		. /	1	00	1			Ruck	k Towso	n Funer	al Ho	me, Inc.	
23a, Part . First the disease, or complications their caused the death. Do Researcher their research present feature. List only one cause on sech line. Immediata Cause (Final disease or condition resolution))	(a	mall	1050	Yor	k Rd.	Toy	wson. M	D. 212	04		
Immediate Cause (First decease or condition resulting in death) Due to (or as a consequence of): Due to (or as a co	23	a. Part1. Entar the disease, or	complications thet caus	ed the death. Do	the mo	de of dyli	ng, such as	cardiac o	or respiretory e	rest,	1	Approximete	
Due to (or as a consequence of): Part II. Other algnificant conditions, account of the cause of death of the cause of death of the cause of death?												Onset and Death	
Due to (or as a consequence of): Consider the properties of the	Examiner Car	Due to (or as a consequence of): Dup Venous The smb USiT Due to (or as a consequence of):											
25. Wes case referred to medical examiner?	Ca tha res	That initiated events Due to (or as a consequence of):											
25. Wes case referred to medical examiner? 1	-	Dot II Ather stacklings and ideas continuing to death but not southing in the underlying and a line in Dot I						l ook pra	22h Did tohacco use contribute to the cause of death?				
25. Wes case referred to medical examiner? 1 Yes 2 No	ran					,							
25. Wes case referred to medical examiner? 1 Yes 2 No		- m	alnutriti	0 4					10	Yes 2 No	3 Prol	oably 4 Unknow	
25. Wes case referred to medical examiner? Yas 2	-		1								T		
25. Wes case referred to medical examiner? 1 Yas No		- lalessite artico ajulatoba								performed?		ailable prior to	
25. Wes case referred to medical examiner? 1 Yas 2 No	-							_				death?	
25. Wes case referred to medical examiner? Sample of Death Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: Anursing Home 5 Residence 6 Other (Specify)									10	res o Dala	1.5	Vac of Ma	
examiner? 1	_										1	1189 ZLINO	
1	25.	Wes case referred to medica examiner?				0.1		e of Death	h (Check only o	ne)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Dascribe how injury occurred 28d. Dascribe how injury			Hospital:	itient 2 ER/Out	patient 3 D	OA OH	ner:	ursing Ho	me 5 Resid	dence 6 □Ott	her (Specif	y)	
2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 28e. Plece of Injury - At home, farm, street, factory, office 28e. Plece of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. Licensa number 29d. Date signed (Month, Day, Year)			28a. Date of Ir	jury 28b. T	ima of	28c. Inju	ry at	1	28d. Dascribe I	now injury occur	rred		
3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) 29a. Certifier (Check only of Number) 2 Medical Examiner: On the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAHED KOULT M-D 7600 OSW DV. Ve., SWTU 411 Towson, MD 21744				July (Odi)				No					
29a. Certifier (Check only one Medical Examiner: On the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. Licensa number 29d. Date signed (Month, Day, Year)		3 Suicide 6 Could	not be Dec Place of I	Injury - At home fer	m. street factor	v. office			28f. Location /	Street and Num	ber or Rura	Il Route Number.	
(Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) 21 - 17 - 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. Licensa number 29d. Date signed (Month, Day, Year) 21 - 17 - 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. Licensa number 29d. Date signed (Month, Day, Year) 21 - 17 - 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		4 ☐ Homicide determ	building,	etc. (Specity)	, on out, laviol	y, onice			City or Tov	vn, State)			
(Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and menner styled. 29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) 01-17-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAHED KOULT M-D 7600 OSW Dr. Ve. (Switz 411 Towson, MD 211-24)		/											
29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year)	298												
FAHED KOULT M-D 7600 OSW Dr. ve, Swite 411 Towson, MD 2124					voi investigation	i, si my c	AMINON, OOS	an occurr	च्च वर गान शास्त्र,	uate and place,	and dde (0	and cadeo(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAHED KOULT M-D 7600 OSW Drive, Swit 411 Towson, MD 21124	29t	. Signature and title of certifia		X	29	c. Licens	sa number	4		29d. Date signe	ed (Month,	Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAHED KOULT M-D 7600 OSW Drive, Swit 411 Towson, MD 21124			18 10m	A	12 7	>4	82.	71	-	01-17.	- 00)	
		tan	~ 000	/	14	- (00	1 '					
	30.	Name and address of person	who completed cause of	death (Item 23a) (Type, Print)			7	1111 5	ni cena	MA	2/12/	
24 Date Stad March Day Varia		FAHE) L	OUL 1 M-	V 1600	osur D	NIM	1 Sh	vu	411	owsort,	1000	114	
	31.	Date filed (Month, Day Year)	Pegis	strar's Signature									

DHMH 16 Rev 6/95



DHMH 16 Rev 6/95

Registrar



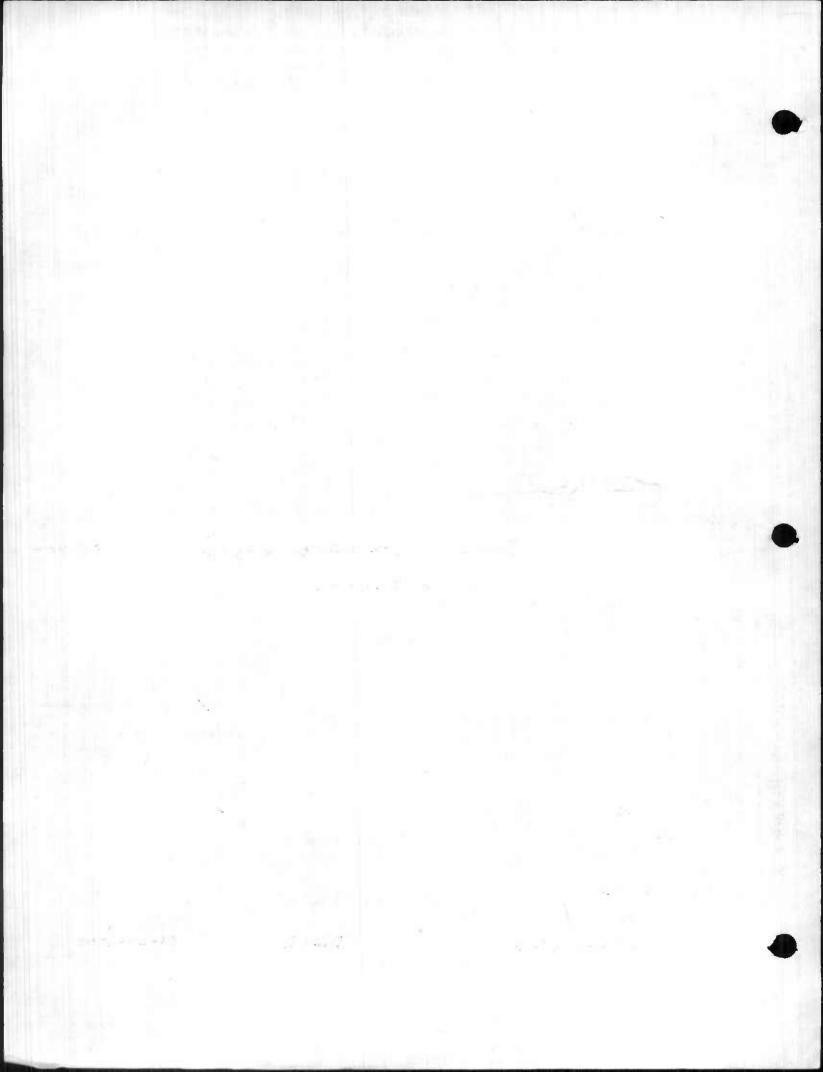
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dawn Marie Watson Jan. 19 2000 6:00 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6 Deep Water Court, Apt. C Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 23 1 **Funeral** Hours Montha 1 M 2 F Yrs. 56 1943 Director 216-42-4121 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Deep Water Court, Apt. C USA 21030 Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 1 ☐ Yes 2 💢 No Specify White Specify: P 3 Widowed 4 Ovivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Safety n/a Secretary Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be . Pages 1 and 2 should be fit ment of Health and Mental Hant: If Item 27 is marked off jury or other traumatic even C. Marshall Williams Yvonne M. Joy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) C. Marshall Williams/father 12 Somers Ct., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Balto. Wash. Crematory 1/21/00 Laurel, MD 21. Signature of Funeral Se 22, Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Severe Chronic obstructive pulmoray disease > 10 years /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Chronic cigarette south Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the Due to (or es a consequence of): 98 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by ti 1) Yea 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law page 2 : 1 ☐ Yes 2 X No 1 Yes 2 No Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Attending Netural 5 Pending 1 Yes 2 No Investigation death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide 8 Hospital 124 hours 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. completely (Check only one) aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 01-20-2000 026575 ND 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) David J. 10 Warren Rd., Suite 110, Cockeysville, MD 21030 Hartig, 31. Date filed (Month, Day, Year) 32. Registrar's Signature souls

DHMH 16 Rev 6/95

Registrar

JAN 21

2000

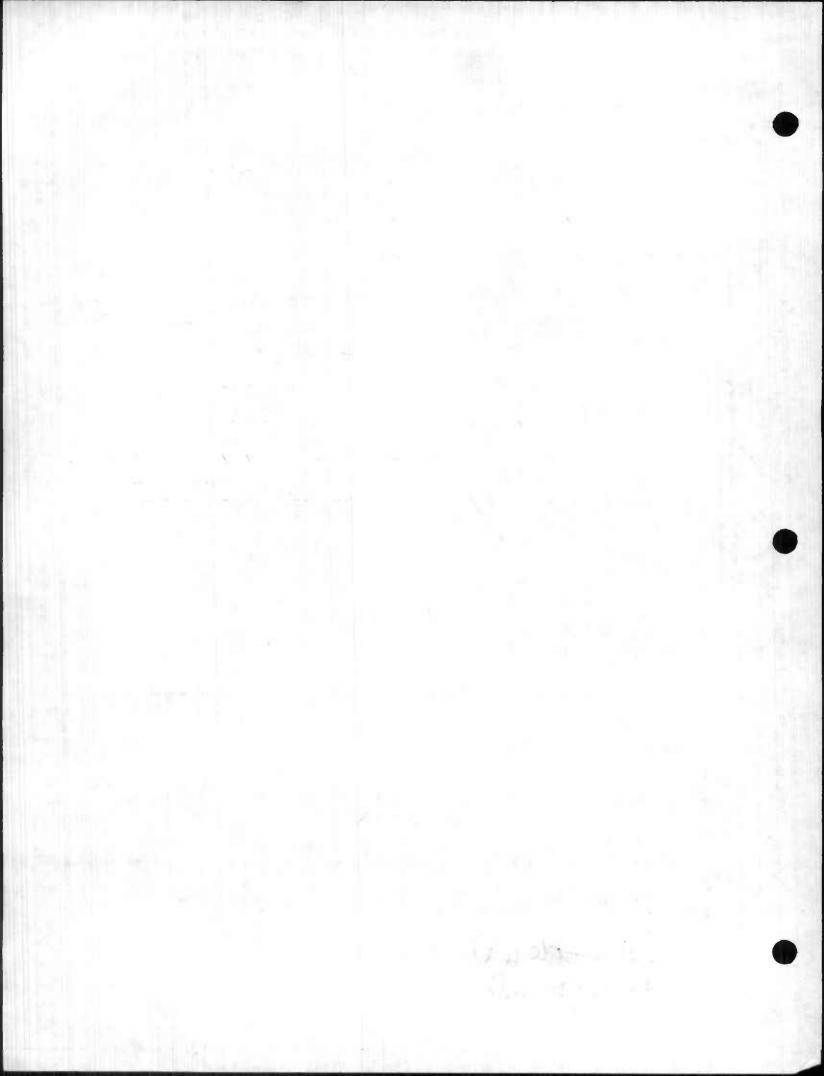


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 11.28 Blane Conrad Wilkinson

cian	MS: #23 PART I, 27, 27,28A Decedent's Neme (First, Middle, Last)		2. Dete of Deal	h Dey Ye	3. Time of Death					
ical	Blane Conrad Wilkinson		January							
iner	e Facility Neme (If not institution, give street and number)	or Location of Deeth	4c. County of I	Death						
	Pier E, Slip 4, 2600 Insulator Dr			N/A						
	. Sociel Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. lest 39	birthdey) Yrs. If Under 1 Yeer If Under 24 If Under 2								
		own or Location			10d. Inside City Limits					
ö		oltimovo Citu			1⊠Yes 2□No					
Directo	Oe. Street and Number	Baltimore City 10f. Zip Code	1	0g. Citizen of Whe	t Country?					
				U.S.A						
Funeral	Pier E, Slip 4, 2600 Insulator 1. Meritel Sielus 12. Wes Decedent Ever in U.S.	(Specify Yes or No-		American Indien,						
nh Lau	Armed Forces? 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No 1 ☐ Yes, Give Yesr or Detes:	13. Was Decedent of Hispenic Origin? If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Specify:	White, etc. White					
			16b. Kind of Busin							
	(Specify only highest grade completed)	(Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired)								
naminan	Elementary/Secondary (0-12) College (1-4or 5+)	Contractor		Construction						
	7. Father's Neme (First, Middle, Last)		Neme (First, Middle, I							
2	John S. Wilkinson	Phy	llis J. Ha	atton						
•		9b. Mailing Address (Street and Number of			ite, Zip Code)					
			inbridge,							
	On Method of Disposition 20b. Place	of Disposition (Neme of		20c. Location - Cit						
	1& Burial 2 ICremelion 3 Hemovel from Stete	tery, cremetory or other place) cimore Cemetery	1/19/2000) Baltim	nore, Marylan					
	21. Signature of Funerel Service Licenses	22. Neme end Address of Fecility								
					al Home, Inc					
	23a. Part1. Enter the disease, or complications that quoted the deeth. D shock, or heart failure. Let only one cause on such line.	1050 York Road	Towson, l		Approximate					
al Examiner	f any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c	a consequence of):								
n/Medical	Due to (or es	e consequence of):								
icia	Pert II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Pert i.	23b. Did to	23b. Did tobacco use contribute to the cause of deat						
Physician		1 🗆 Y	1 Yes 2 No 3 Probably 4 Unknown							
Completed by			24e. Wes e		24b. Were autopsy findings eveilable prior to completion of cause					
odu					of death?					
0			1/X/Y	es 2 No	Yes 2□ No					
90	25. Was case referred to medical axaminer?									
9	1 ☐XYes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/		ng Home 5 ☐ Resid							
Certification:										
Cati	2 Accident investigation FOUND		UNKNOWN							
	3 Suicide 4 Homicide Solution of the determined building, etc. (Specify)	City or Tow	281. Location (Street end Number or Rural Route Number, City or Town, Stete) 2600 INSULATO							
	TOURS THE	TER	BALTIM	ORE, ME						
edicai	1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examinetion and manner stelled.	ge, deeth occurred et the time, dete end pi and/or investigation, in my opinion, deeth o	ace, and due to the d occurred at the time, o	ause(s) and mann late and place, and	er es stated. I due to the ceuse(s)					
M	19b. Signature and title of certifier	1	29d. Dete signed (Month, Dey, Year)							
	M Statole 10	-3 - 1 - 44	January	15, 2000						
	0. Name and address of person who completed cause of deeth (Item 23	e) (Type, Print)								
	Control of the contro			400						
	TLATON (OCKO M)	111 Penn Street	, Baltimor	e, Maryl	and 21201					
e	32. Registrer's Signeture JAN 2 1 2000		, Baltimor	e, Maryl	and 21201					

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()
AMEND ITEM: #26 PER VERBAL RESPONSE 1 Certificate of Geath 1-21-2000 WR. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Bernadette M. Westkamp 07 2000 MULLER 9:52 BM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner Union Memorial Hospital Baltimore City Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 9, 1915 9. Birthplace (Stete or Foreign 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours Min 1□ M 2QF Baltimore, Maryland 216 03 6772 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Towson Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Towsontowne Court Apartment 202 21204 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) NA Elementery/Secondery (0-12) Homemaker Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Sauter Lenora Meyd 01 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elmer Westkamp (Husband) 200 Towsontowne Court Apartment 202 Towson, Maryland 21204 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition eny injury or c 1 X Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. January 11,2000 Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical SEPSIJ WILKS Examiner Due to (or as a consequence of): Examiner certificate be executed the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of) physician Physician/Medical Due to (or as a consequenca of) 88 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I He detached 2 1 Yes 2 No 3 Probably 4 Unknown MYDCANDIAL INFARCTION Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed CEREBRAL VASCULAR ACCIONA. completion of cause of death? certificate hes 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 5 Pending investigation within 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.
2☐ Medicaf Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 07 2000 M.D. January AT 2438946

State Registrar

JAN 2 2000

Huana

30. Name and address of person

31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

Union

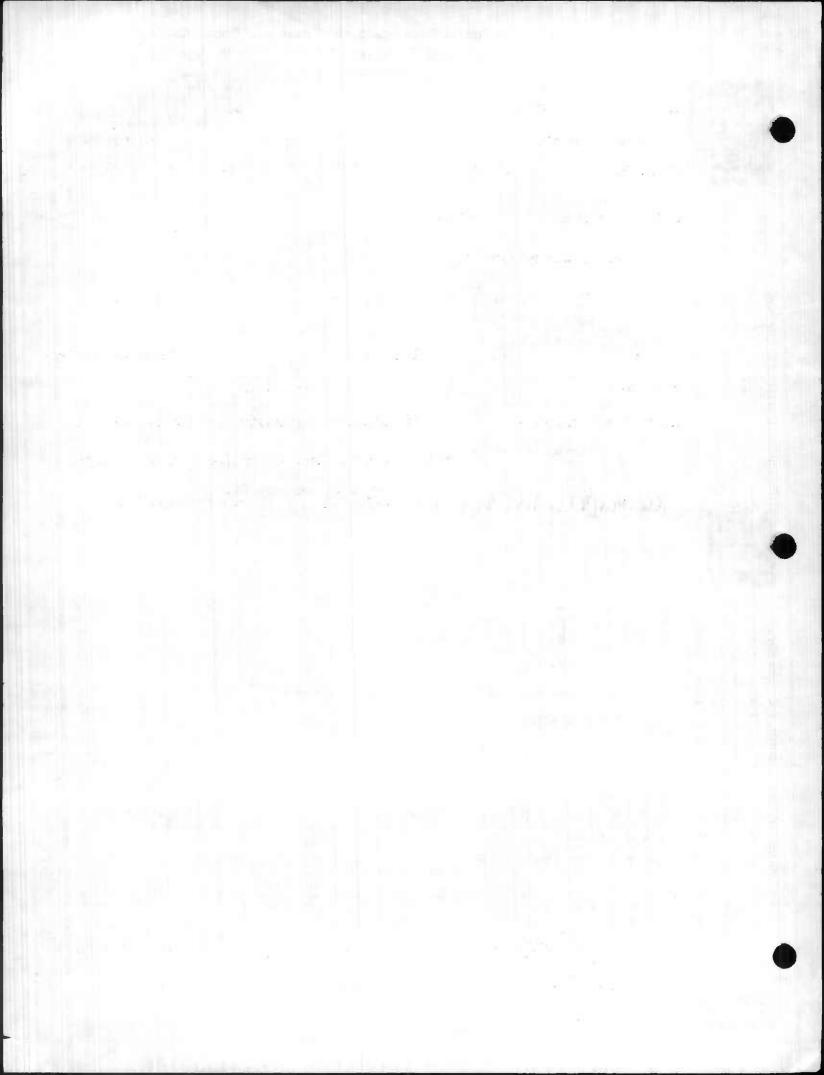
who completed cause of death (Item 23a) (Type, Print)

pospital Baltimore,

Memoria

DHMH 16 Ray 6/95

Box 68760



DHMH 16 Ray 6/95

10-00

SEOR

muliply sing Magazin Caren a Characteristic Constant

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 10:50H Mei Chun Ng-Yeung 2000 /Medical City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Woodbourne Ave 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mir 1□M 2ᡚF 212-94-7363 81 Yrs. **Director** Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28e-f show with the Maryla the Medical Examiner numb be notified at Yes 2 No Funeral Director NA Baltimore 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? United States 21212 318 Woodbourne Ave Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 12. Was Decedent Ever In U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yas 2 No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Chinese 1 ☐ Yes 2 X No Specify: à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental is marked (Unknown) Chup Yeung 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) important of Health as important: if itsm 27 is n any injury or other once. 318 Woodbourne Ave Baltimore, MD 21212 Yuk Sun Ne/husband 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1-23-00 Druid Ridge Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility CAFA Stephen D. Londmann, P.A. 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury and P.O. Box 68760. the attending physician that initiated events resulting in death) Last Due to (or as a consequence of) ipital or Attending Physician: The law requires that the de-ours after death.

weral Director: After this cardificate has been signed by the a filled in by the tuneral director, page 2 should be detached. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? intarction 1 Yee 2 No 3 Probably 4 Unknown Division of Vitai Records, Be Completed by 24b. Wera autopsy findings available prior fo completion of causa of death? 24e. Was an autopsy performed? 2 NO 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 27. Manney of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of To the Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. 29e. Certifier 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number of death (Item 23a) 30. Nama and address of person

DHMH 16 Rev 6/95

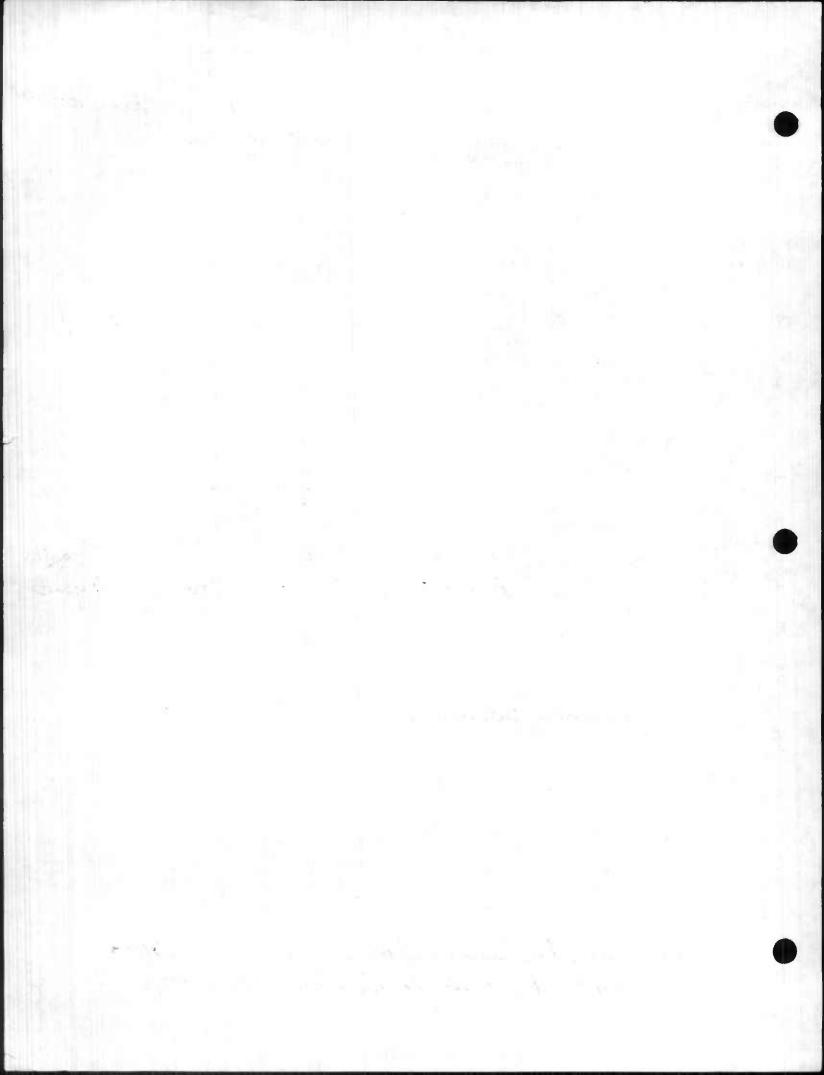
State

Registrar

31. Date filed (Month, Day, Year)

JAN 21

32. Registrar's Signatur



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \cap \cap Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death 16, 2000 Sarah Ann Younker **JANUARY** 4:15PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HAGERSTOWN WASHINGTON RAVENWOOD LUTHERAN VILLAGE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) May 7,1947 Birthplace (State or Foreign Country) W 7. Age (In yrs. last birthday) 6 Sex 10 M 200F Days Months Hours 52 Yrs. 215-42-3741 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Washington Hancock 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21750 USA 13213 Woodmont Road 12. Was Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elizabeth Gallion Ernest Morris 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Plece of Disposition (Name of cemetery, cremetory or other place)

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line.

Due to (or as a consequence of):

Due to for es a consequence of)

Due to (or as a consequence of)

Br ten Diflanci Ity per teny ion

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

HE POICLEDOIN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

13213 Woodmont Road Hancock, MD 21750

22. Name and Address of Facility
Grove Funeral Home, P.A.

Pleasant Grove Cemetery 1/19/2000 Warfordsburg, PA

141 W. Main St. Hancock, MD 21750-0368

20c. Location - City or Town, Stete

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

2 No

Location (Street end Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

24a. Wes en autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Wera autopsy findings evaileble prior to

completion of cause of death?

1 TYes 2 □ No

-17-00

Physician /Medical Examiner

Department of important: If eny injury or page.

Physician

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

Ray E. Younker/Husband

4 Donation 5 Dother (Specify)

21. Signature of Funeral Service License

1 Burial 2 Cremation 3 Removal from State

25 Was case referred to medical axamine?

5 Pending investigation

6 Could not be determined

20a. Method of Disposition

Immediata Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last

1□ Yes 2☑ No

27. Manner of Death

1 ONetural

2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie ale

Funeral

Director

ms 23a or 2

*natural", or item

iges 1 and 2 should be filled within 72 hours effect to Heelih and Mental Hygiena. If them 27 is marked other than "natural", or filed rother thaumate event, the Media.

Maryland 21215-0020

Baltimore,

Box 68760.

Records, P.O. Ann YOUNKER

of Vital Sarah

Division

Pages 1

the Maryland

Physician/Medical Examiner

Completed by

Certification: To Be

edical

the

anding physicien and use as the burlet-transit The law requires that the death certificate be axecuted After this funeral Attending s efter death.

filled in by 24 hours within 2 94

8

State Registrar **DHMH 16 Rev 6/95**

12930 OBEHICC BL1 ROZA 400 31. Date filed (Month, Day, Year) JAN 2 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated

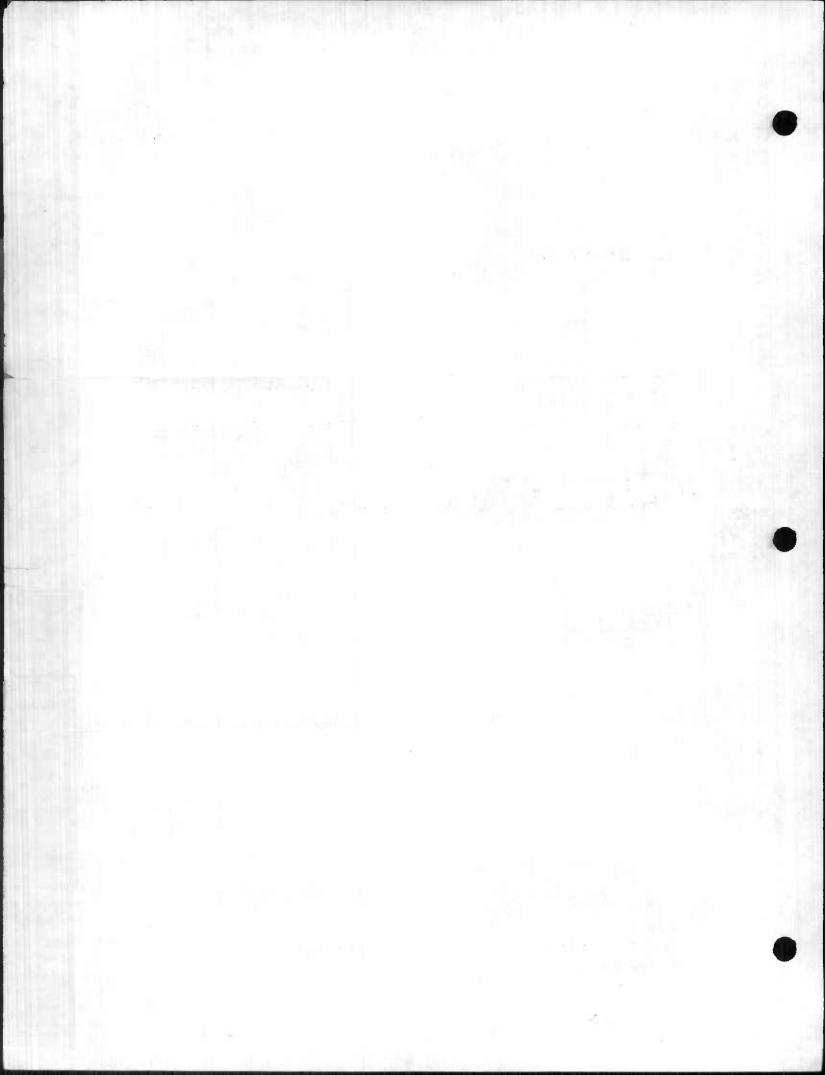
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D22313

HAGBRY TOUN

1 Yes 2 No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certificate of	f Death	Re	g. No.	01433			
Physic	ian	Decedent's Neme (First, Middle John	. Last) Robert	,	Brooks		2. Dete of Death Month	B*3, 20	3. Time of Death			
/Medi			·		DIOOKS			_				
Exami	ner	4e. Feellity Name (If not Institution, 710 Armiger	- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10)		4b. City, Town, or L Huntir	ngtown	A COLUMN TO STATE OF THE STATE				
Funeral Director		210 10 3331	6. Sex 7. A 11 M 2 □ F	Age (In yrs. lest birthdey) 76 Yrs. If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month), Dey, Year) 9. Birthplece (Stete or For Country) Mar. 19, 1923 Maryland								
p		Usuel Residence of Decedent 10a. Steta 10b. County		10c. City, Tow	m or Location				10d. Inside City Limits			
n the Marylan r 28a-f ehow	5		lvert		Huntingtown	-			1 Tes 2 No			
28e	rect	10e. Street end Number	LVCIL		10f. Zip Code		10	g. Citizen of Wh	at Country?			
ath with	Funeral Director	710 Armiger Roa			206			USA				
21215-0020 d within 72 hours after death with the Manyland glena. r than "natural", or flema 23a or 28a-f show in Medical Examinet mat be incidined at	by	11. Meritel Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yas 2 If Yes, Give Yaar or Dates:	?	13. Was Decedant of If Yes, specify Cu		pecify Yas or No- Rican, atc.)	Black,	American Indian, Whita, atc. Black			
15-00 72 hours "netural",	eted	15. Decedent' (Specify only highes		16e	Decedent's Usuel Occ (Give kind of work don	upation e during most of work	king 1	6b. Kind of Busi	ness/Industry			
121 vithin han	Completed	Elemantary/Secondary (0-12)	Collega (1-4or	5+)	(Give kind of work don life. DO NOT use reti Bricklayer			Magana	***			
CA DOP	ပိ	17. Fsther's Name (First, Middla, L	act)		Diicklayel		ne (First, Middle, M	Mason:	•			
yland ould be f Mental i Mental i marked of matic ava	Be C	Herbert		rooks		Jeanett			kall			
Mar 12 sh hand hand rie m	To	19a. Informant's Neme/Reletionsh Annie Brooks/Wi			o. Mailing Address (Street O Armiger F							
the sa		20a. Method of Disposition	• 	20b. Plece	of Disposition (Name of	1			ity or Town, State			
Peg nent ment ury o		1 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (Sp)	ent UMC Cen		/11/00 Ht	untingto	ngtown, MD			
Baltimore, permit. Peges 1 ar Department of Hea important: If item; any injury or other once.		21. Signeture of Funerei Service L	C. Lewell	1		ress of Fecility Se	well Fune	eral Hon				
Physician // Medical Examiner but springer by ships privately and street by the private franchis franc	Examiner	23a. Pert1. Enter the disease, or ahock, or heert fellure. List of limited the cause (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants	^	Due to (or as e	CANCO,				inferval Between Onset and Deeth Who			
5 0 6	n/Medical	Cause (Diseesa or injury that initieted evants resulting in death) Last	d	Dua to (or as a	consequence of):							
.O. Box the death cery the ettendin	sicia	Pert II. Other significant condition	e contributing to death t	out not rasulting i	n the underlying cause of	given in Pert I.	23b. Did tok	pacco use contr	ibute to the cause of death?			
U 25 0 25	by Physician/						1 □ Ye	s 2□No 3	Probably 4 Unknown			
of Vital Records, P Physician: The law requires that this certificate has been signed b rai director, page 2 should be dete	Completed b						24e. Wes en	ed?	24b. Were autopsy findings evailable prior to completion of cause of death?			
Vital Re licien: The k certificate ha		25. Wes case raferred to medicai					1 🗆 Yes		1□ Yas 2□ No			
of Vita Physician: this certific	To Be	axaminar?	Hospitei:	ent 2 ER/O	utpatient 3 DOA	Where	th <i>(Check only one</i> ome 5 ☐ Residar	/	(Specify) HOSDICO			
Physer this seraid		27. Menner of Death	28a. Dete of Inju	ury 28b.	Time of 28c. Inj		28d. Dascribe hov					
VISION Attending I r death. ector: After by the funer	atio	1∠Netural 5 Panding 2 Accident investig	etion	A		☐ Yes 2 ☐ No	^	U/A				
DivISion To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	3 Sulcide 6 Could no determine	and 286. Piece of in	jury - At home, fe tc. (Specify)	erm, street, fectory, office	e	28f. Location (Str. City or Town,	eet and Number Steta)	or Rural Route Number,			
Lospit 4 hour uners	edical	(Check only 2 Medical E	Physician: To the best xaminar: On the basis of	of my knowledge	a, death occurred at the	time, dete end plece,	and due to the car	use(s) and menr	ner as stated.			
the F the F	Medi	one)	end manner st	leted.								
5 × 5 9		29b. Signature and title of dertifier	11/	10	. ()	nse number	29	1/0/	(Month, Day, Year)			
		19700	5//	7 11	Y	054076		1/9/	Juve			
		30. Nama and address of parson w Rodell E. Cr				Prince Fra	dori ele	MD 2067	0			
CA	ate.	31. Deta filed (Month, Day, Year)		ray's Signeture		Prince Fre	derick,	TID 400/	O			
Sta Registr		IANO	7 2000	General	9. 1.	m V.						

erial of a life agencies green mills after the property of the second state of the second seco

STATE OF THE STATE

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 🗍 🧍 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 1, 2000 10:00am January Cecilia Agnes Brown 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Carroll Sykesville 1667 Gemini Drive If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey). 94 Yrs. If Under 1 Year 8. Date of Birth Month, Day, Year 905 9. Birthplece (State or Foreign 1 M 2 XF Months Days Hours Onio 086-12-0873 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Sykesville MD Carroll 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 1667 Gemini Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 8 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Lu Lu Ruppert Harry Haines 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Cecilia A. Ekeroth (Daughter) 1667 Gemini Drive, Sykesville, MD 21784 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 18 Burial 2 □ Cremation 3 □ Removal from State 1/3/2000 Sykesville, MD Springfield Cemetery 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that ceused the daeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) rolle Due to (or es e consequence of): VILLOJR veplo relegies Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 2 1 No 1 ☐ Yes 2 ☑ No 1 Yes 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physician and the buriel-transit The lew requires that the deeth certificate be executed Records, P.O. Box 68760, for use es ed by the e signed by t peed 188 page 2 this certificate Division of Vital or Attending Physicien: director, funerel After death. after death.

Director: A
d in by the f within 24 hours aft To the Funeral Dis completely filled in Hospital

Physician

/Medical

Examiner

Director

Funerai

þ

Completed

Funeral

Director

7 le marked other than "natural", or itema 23a or 28a-f ehow traumatic event, tra Mosical Examinal maint be notified all

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantel Hygiene. Important: If them 27 is marked other than "natural", or items 23e orly injury or other traumstic event, the limit

Physician

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

with the Meryland

25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Mennes of Deeth 1 Matural

29a. Certifier

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of quitte

29c. License number

29d. Date signed (Month, Day, Year)

January 2, 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. Michael Costello, MD 730 Old Liberty Road, Eldersburg, MD 21784 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

JAN 0 5 2000



1 🗹 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end manner as steted.

IRRO SERVER

OSSE & IT MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year Smith Bankerd Farver 3:00PM January 4, 2000 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 5708 Strawbridge Terrace Eldersburg Carroll If Under 1 Year If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Aug 16, 1937 5. Social Security Number Birthplaca (Stata or Foreign Country) 1**⊠** M 2□ F 220 - 34 - 6090 Yrs Usuai Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No Eldersburg Carroll Maryland 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5708 Strawbridge Terrace U.S.A. 21784 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 M Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) Construction Cement Truck Driver 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Bankerd Chester Gwendolyn A. 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5708 Strawbridge Terrace Eldersburg, Maryland 21784 Bankerd/wife Evelyn E. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Marriottsville Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Crest Lawn Memorial Gardens 1/7/2000 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Zumbrun Funeral Home & Monument Co. 6028 Sykesville Road Eldersburg, Maryland 21784 the tha disease, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, or heart failure story one cause on each line. Intarval Between Onsat and Death Immediata Causa (Final ing Carcinoma disaasa or condition rasulting in daath) Dua to (or as a consequence of): Saquantially list conditions, if any, laading to immadiata causa. Entar Undartying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequanca of): Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of causa of death? 22010 1 Yas 25. Was casa rafarrad to midical 28. Placa of Daath (Check only ona) axaminar Hospital: Othar: 4 Nursing Homa 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

P

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Marical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours efter c Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other treumetic event, the Medical Examines once.

Baltimore, Maryland 21215-0020

death with the Maryland

es the buriel-transit end been signed by the ettending physician should be deteched for use as the burie this certificate filled in by the funeral

hes

After death.

Attending Physician:

i or Attendi efter death Director:

To the Hospital o within 24 hours of To the Funersi DI

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be 2 Certification:

1 1 1 1 1 1 1 1 1	Sale Control
7. Manner of Death	
Naturat	5 Pending
ST	Invactiontion

3 Suicida 6 Could not be datarminad 4 Homicida

28a. Data of Injury (Month, Day Yaar) 28a. Ptace of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

H46326

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

1/5/2000

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signatura a ditta

29a. Certifia

29d. Data signad (Month, Day, Yaar) 29c. Licansa numbar Fomily

rachice(D.C. 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

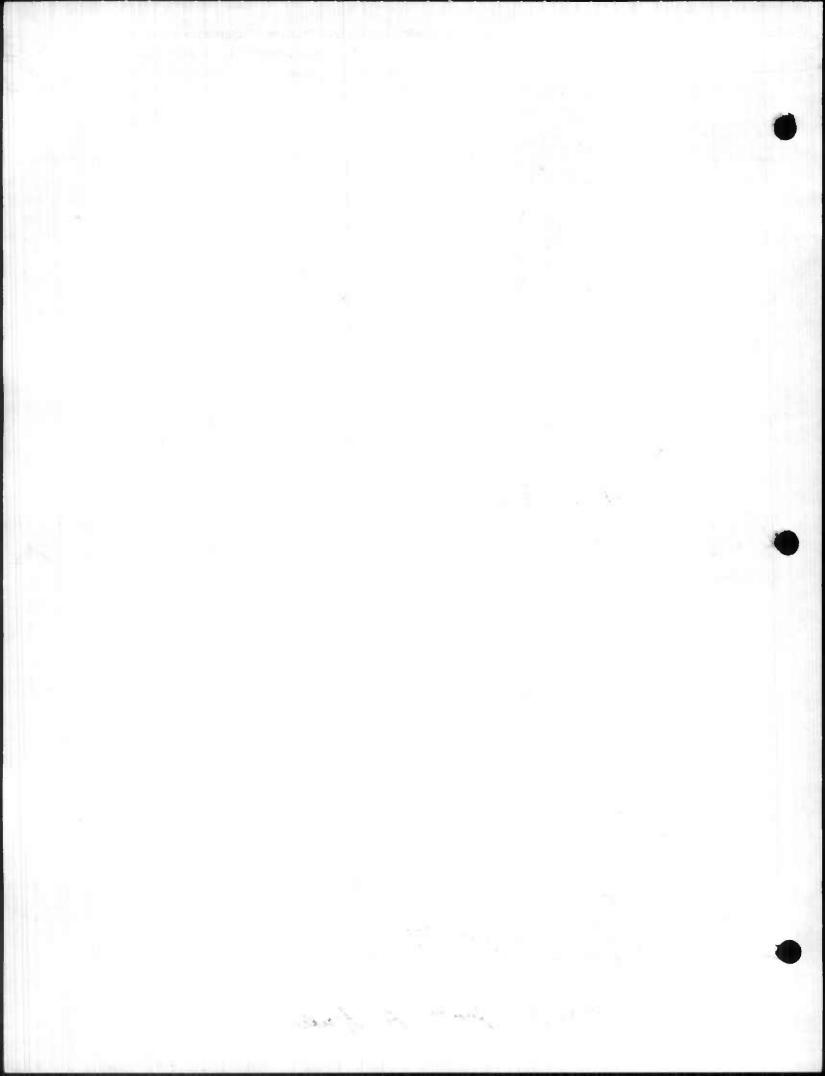
Dr. Randi Braman 6190 Georgetown Blvd. Eldersburg, MD 21784

State Registrar

Medical

31. Data filad (Month, Day, Year) JAN 0 5 2000





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month **Physician** oand luanita (grace 11:02 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County General Hospital Westminster Carroll If Under 24 Hrs. If Under 1 Yaer 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Hours 492-38-6138 96 31,1903 Director Mar Missour. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Westminster 1 Yes 2X No Directo Maryland Carroll 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 753 Gist Road 21157 USA thems 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yea, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours after Hygiene. ther than "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ď 3☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carroll County College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien, Important, if then 27 is marked other tha any injury or other traumatic Public Schools School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Durward Lauderback Emma Clemmings 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Sharon Chilcoat, daughter 1026 Silver Run Valley Rd, Westminster, MD 21158 20b. Place of Disposition (Neme of cematery, cremetory or othar place) 20s. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Paul's Cemetery 1/6 Upperco, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenser M00723 Eline Funeral Home 934 South Main St, Hampstead, Md 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sclevotic Cardiovascular Disease physician and s the buriel-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760, Due to (or es a consequence of). 080 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? pege 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica axaminer? or Attending Physicien: Be 26. Place of Death (Check only one) To 1 Yes 2 Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 3 DOA 1 Inpatient 2 ER/Outpatient After this 27. Manne di Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c, License number 29d. Date signed (Month, Day, Year) D39296 Westmin Stor MD of person who completed cause of death (frem 23a) (Type, Print) Rickett 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

JAN 0 5 2000

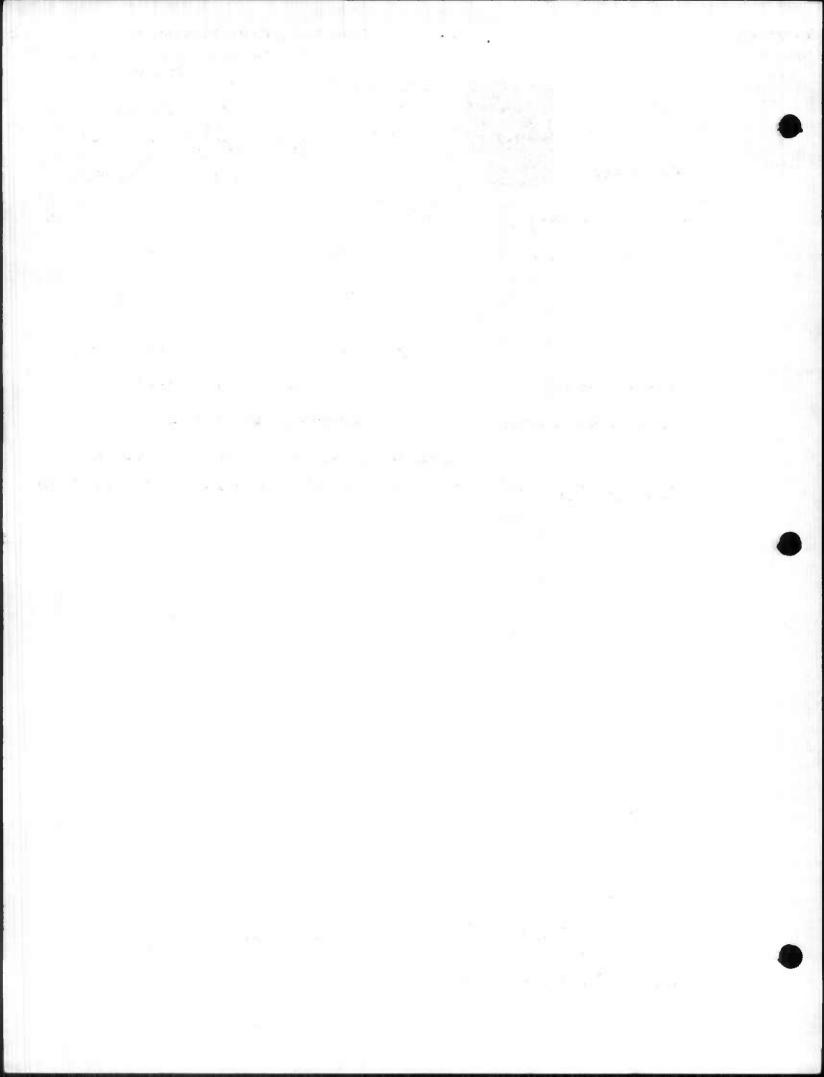
Me some it

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State	oi iviai yiai iu	-	ificate of		мена пу	Reg. No.	0 01	37		
	Physici		1. Decedent's Neme (First, Middle, Last) GEORGE A. BEL	. L				2. Dete of De Month	Dev ,	Yeer 3. Ti	me of Death		
7	/Medi Examir		4a. Facility Name (If not institution, give street and not be cleared w. McCheard	mber) Mem	orial	Hosp.	4b. City, Town, o 201-7 Nisfield	Location of Dead	4c. County of Deeth				
	Funeral Director		5. Sociel Security Number 214-44-0460 6. Sex 10x № 2□ F	7. Age (In yrs. les	st birthday) Yrs.	If Under 1 Yeer Months Deys	if Under 24 Hr Hours Mir	S. 8. Dete of Bir		9. Birthplece (S Country) Marylar	tete or Foreign		
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Insi	Ide City Limits		
	Many Fired	to	Maryland Somerset	М	arion						Yes 2 No		
	th with the 23a or 28a at be not	al Director	10e. Street and Number 4910 Shelltown Rd.			10f. Zip Code 2183	8		10g. Citizen of V USA	Whet Country?			
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "naturel", or items 23a or 28a-f show any figury or other theumatic event, its Madical Examiner must be notified at ance.	by Funeral	Armed F	2 No ive No		as Decedent of H Yes, specify Cub		Specify Yes or Norto Rican, etc.)	14. Rec Biac Specify	a - American Indick, White, etc. White			
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed		16a. Decede	nt's Usuei Occup	pation during most of w d)	orking	16b. Kind of Bu	usiness/industry			
121	filed within Hygiene. Wher then	Completed		(1-4or 5+)		o <i>not use retire</i> C Driver			Tran	sportati	.on		
d 2	illed with Hygiene. other than	Be Co	17. Fether's Neme (First, Middle, Last)		2200			eme (First, Middle					
ylar	should be and Mental I	To B	Robert Allan Bell				Mary	Virginia	a Bedswo	rth			
Maryland	2 sho		19e. Informent's Neme/Reletionship (Type, Print)					Rural Route Numb					
	1 and Health am 27 other tr		George A. Bell Jr./Son 20a. Method of Disposition	20b. Pled	ca of Disposi	tion (Neme of		Dete Dete		City or Town, Ste	ate		
timore,	tment of I		1 Donetion 5 □ Other (Specify)		ceth Met	hodist Ce	metery	1/7/00	Shellt	own, MD			
Ba	Departme Importan any injur		21. Signeture of Funeral Servica Licensee	101129				Funeral Pocomoke			l Assoc		
2	Physician /Medical Examiner		23e. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the deeth.	Do not enter	the mode of dyle	ng, such es cardi	ac or respiretory e	prrest,	Appro	ximete el Between end Deeth		
	ate be axecuted hysician and the bunal-transit	edical Examiner	resulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underfying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest	sible proposed some some some some some some some some	As a consequence of the conseque	rations. Aci	n Par dosis	emo	nia				
Box 6	eath certific attending p for usa as	Physician/Me	d										
0	the all	ysic	Pert II. Other significant conditions contributing to d	eath but not resulting			ven in Pert I.	23b. Did	tobacco uas co	ntribute to the ca	use of death?		
S, D	es that the death cer igned by the attendin be detached for usa	by Ph	HTN, Hyperlip	demia	1 /	ossible	010	1)	-Yee 2□ No	3 Probably	4 Unknown		
Records	requir seen s hould	Completed b	Inf. M. I.; Hyper	glycen	ria,			24a. Wes	en autopsy omed?	24b. Were euto evelleble completio of deeth?			
Re	Tha la ta has	omo	Jacco How	iction	1			10	Yes 2 No	1 □ Yes	2 No		
Vita	ysician: Tha law s certificata has b director, paga 2 s	Bec	25. Wes case referred to medical examiner?				26. Plece of D	seth (Check only	one)				
0	Physic this co	2	1 ☐ Yes 2 No Hospital:	·	R/Outpatient	3 DOA Oth	4 LI Nursing	Home 5 Resi	idence 6 Oth				
O	ding th. After funat	tlon		oth, Day Year)	8b. Time of Injury	28c. Injui Woi M 1 □	rk? Yes 2□No	280. Describe	now injury occur	red			
Division of	To the Hospital or Attending Physician: which 24 hours after deals as a feet deals To the Funeral Director: After this certifica completaly filled in by the funaral director,	Certification:	3 Suicide 6 Could not be determined 28e. Plec	e of Injury - At home ing, etc. (Specify)	e, ferm, stree	et, fectory, office		28f. Location (City or To	Street end Numb wn, Stete)	per or Rurel Route	Number,		
	Hospita 24 hours Funeral etaly filler	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the to 2 Medical Examinar: On the to and make the control of the total one and make the control of the total one and make the control of the control of the control one of the control of								use(s)		
	vithin To the	Me	29b. Signeture end title of certification	M.D.		29c. Licens	se number	0.0		d (Month, Dey, Ye			
	3					1)-	00544	122	1/5	12000			
)	,	30, Neme end eddress of person who completed cau Sovial R. Baral; MD;	se of deeth (Item 2: 1604 Mil	3e) (Type, P	int) 57. ;	Pocom	oke;	MD 2/2	351			
	Sta Registr		31. Dete filed (Month, Day, Year) JAN 0 5 2000	Registrer's Signatur	· 4.	Spark							

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth **Physician** Month 6:00 ann ester 00 /Medical 4a. Facility Nema (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Street r If Under 24 Hrs. 6. Hours Min. if Under 1 Yeer 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) Funeral 10 M 2 F Months Days 220-03-Yrs. Director Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "nature!", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Stete 10b. County 10d. Inside City Limite 1 Yes 2 No Director Worces 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 1863 Funeral treet 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva/ Year or Datas: Rece - American Indian, Bleck, White, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1 Naver Merried 2 Merried Specify: Black 1 ☐ Yas 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Bueinass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 3rd grade 17. Fathar's Nama (First, Middla, Last) Domestic 18. Mothar's Nama (First, Middle, Malden Sumama) 19e. informent's Name/Ralationship (Type, Print) 20b. Place of Disposition (Nama of comatery, crematory or other placa) DOFO Thy 20a. Mathod of Disposition 20c. Location - City or Town, State Date Burial 2 Cramation 3 Removel from State Ebenezer Church Censtary 1-8-00 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licentific 22. Nema end Addrass of Fecility Funcial Bennic Smith 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** CONGESTIVE HEART FAILURE /Medical Immediate Cause (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequenca of):
THEROSCLEROTIC Physician/Medical Examiner VASCULAR DISEASE The lew requires that the deeth certificate be executed attending physician end for use as the buriel-transit Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in death) Last T DIABETES

Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, INFARCTION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormed? s certificate hes b 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

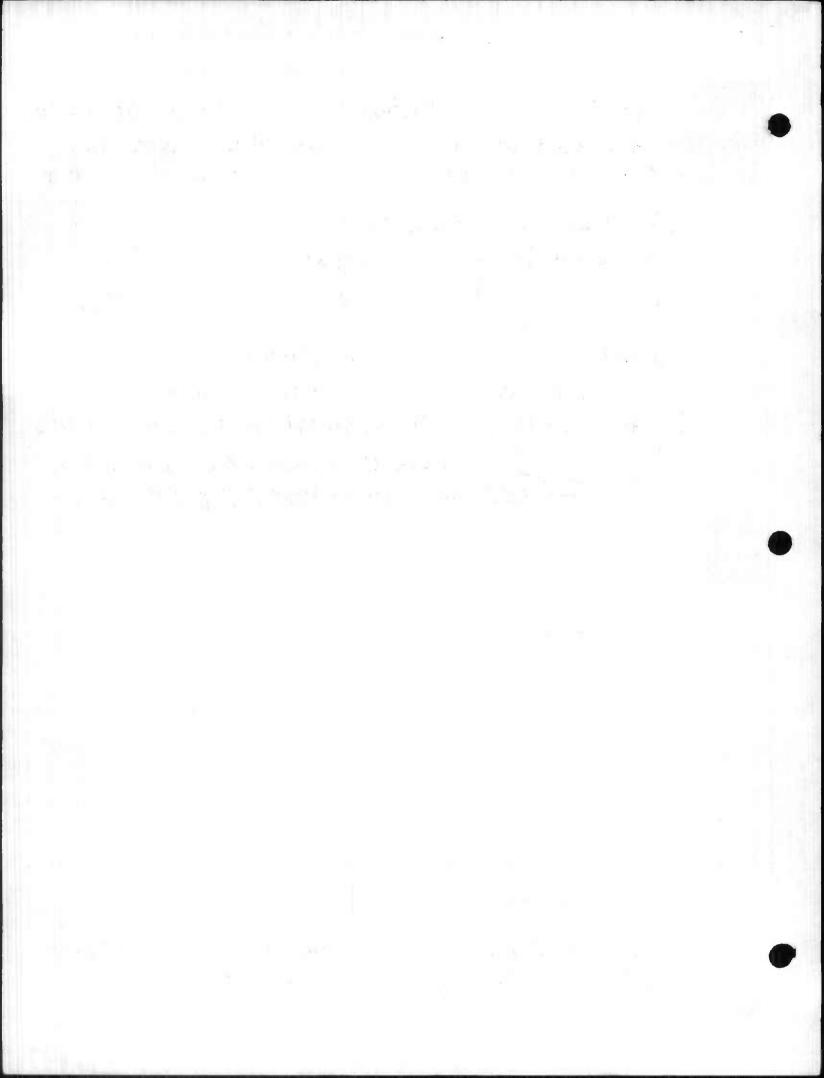
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 1 Netural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated. Medical 29e. Cartifler 2 Medical Examinar: On the basis of axamination and/or investigetion, in my opinion, death occurred at tha tima, data and place, and dua to tha ceuse(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Deta signed (Month, Day, Year) 30. Name end addrass of person who complated causa of death (Item 23a) (Type, Print) RD PINEBLUFF SALISBURY

DHMH 16 Ray 6/95

State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 01 **Physician** 02 WILLIE BUCHANAN 5:52 a.m. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton P. G. If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F 579-48-6132 94 11-26-05 Director Mississippi Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location Bladensburg 10d. Inside City Limits than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at Md. P. G. 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20710 U. S. A. 5037 60th Avenue Funeral deeth 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status filed within 72 hours after 1 XYes 2 No Navy 1 Never Merried 2 Merried 21215-0020 Specify: Black 1 Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Elementary/Secondery (0-12) 6th College (1-4or 5+) Barber Self-Employed 18. Mother's Neme (First, Middle, Meiden Sumame) Virginia Johnson Baitimore, Maryland 17. Fether's Neme (First, Middle, Last) Arbry Buchanan Be Peges 1 and 2 should be in nent of Heelth end Mentel I int: If Item 27 is marked of 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Joseph Dr. Clinton, Md. 20735 Laura B. Samuel (Daughter) permit. Peges 1 and Department of Heelth Important: If Nem 27 any Injury or other tr once. 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 1-6-00 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Maryland National W. H. Bacon Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 3447 14th St., N. W. C. Bacon CC0361 Washington, D. C. 20010 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Obstanelne Rulming disease Immediate Cause (Finel 304eans disease or condition resulting in deeth) Examiner Examiner ician and burial-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of) for usa signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 10 Yee 2 No 3 Probably 4 Unknown Demonha by Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? pege 2 a 2 1 No 1 ☐ Yes 2 ☐ No certificate funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 Divetural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-2,2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Sumatte Rd # 307. clinton made 735 Perteens surech A. 7501 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 0 3 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

\(\) nil. In Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY EVELYN BENNEAR JANUARY 2000 /Medical 4:40 AM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Yaar | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Dafa of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 1□M 2⊠F Director 235-16-7057 JUNE 16,1914 WEST VIRGINIA Usual Residence of Decedent the Meryland 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f ahow 1 Yas 2 No Director MARYLAND PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7704 HYACINTH COURT 20707 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental hygiena. Important: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Examinations. Black, Whita, etc. 1 ☐ Yas 2 No If Yes, Giva Year or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL MCLERK RETAIL 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nema (First, Middle, Last) DELBERT McDANIEL CARRIE NEVADA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MONA HAMMITT-GRANDDAUGHTER 7704 HYACINTH COURT LAUREL, MARYLAND 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CREMATORY 1-5-2000 BRENTWOOD, MARYLAND 22. Nama and Addrass of Facility no of Funeral Service License FORT LINCOLN FUNERAL HOME 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or aspiratory arrest. MARYLAND 20722 shock, or heart failura. List only one cause on each lina. Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) FAILURE 6 HRS. RESPIRATORY Examiner Due to (or as a consequence of) Examiner 2 HRS NEUMONIA physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. METASTATIC CARCINOMA LUNG mouth Completed by Physician/Medical Dua to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Asthma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No DSTEDBOYDSIS 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical axaminer?

1 Yes 2 No 8 26. Place of Deeth (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Inpatient 2 ER/Outpatient 3 DOA 1 A hours after death.
A hours after death.
A hours after death.
And the hours after the hours after the hours. 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Cartification 1 DNatural 5 ☐ Pending 1 | Yas 2 | No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of continue

State Registrar 31. Data filed (Month, Day, Year)

JAN 0 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sports

Same of

JAN 0 = 2000

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01661 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Nonth Day 5, 2000 **Physician** Raymond Eugene Bonner 8:33 AM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON MEDICAL CENTER GREATER BALTIMORE If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Days Hours 193-14-4541 Director 73 Pennsylvania Jan. 12, 1926 RAYMOND Uaual Raaidence of Decedant 10a Stata 10b County 10c City Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Maryland Carroll Director Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Name 23a 6944 Cable Drive 21104 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No 14. Race - American Indian 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. 1 ☐ Nevar Married 2 ☑ Married 'natural', or 1 ☐ Yas 2 ☑ No Specify: If Yas, Giva Yaar or Datas: 1944-46 Specify. à 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. ther then Elementery/Secondary (0-12) College (1-4or 5+) 12 Postal Worker Federal Government 17, Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) and Mental Eugene Bonner Anna Donegan 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Important: If Item 27 is any injury or other treat 2009. Margaret M. Bonner - Wife 6944 Cable Drive, Marriottsville, Maryland 21104 20b. Place of Disposition (Nama of commatary, crematory or other place)
St. John's Russian
Orthodox Cemetery 20c. Location - City or Town, Stata 20a. Mathod of Disposition 8 1 図 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 1/9/00 Nesquehoning, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Gasch's Funeral Home 21. Signature of Funaral Sarvice Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting In daath) mach Examiner Examiner physician and the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 275-No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yas 2 ☐ No of Vital 25. Was case rafarred to medical examinar? 89 26. Place of Death (Check only ona) 1 Yas ZNO Hospitet: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To mpatient 2 ER/Outpatient 3 DOA this 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Affer t Division Attending Netural 2 Accident 5 Panding invastigation death. 1 Yes 2 No Director: / 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, tarm, street, fectory, office building, atc. (Specify) 4 | HomicIda after 6 24 hours at Funeral Dietely filled i Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and Affle of certif

State

Registrar

JAN 0 6 2000

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Pri

D 6569 N. C. 32 Registrar's Signatura G.

les ST, BALTMAR MD

2000

D30929

JAN 2 2 2000 June 10 June

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Carlotta D. Bailey 9:10AM JAN 00 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Ft. Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys 75 002-18-8217 New Hampshire Director Nov.2,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Prince George's Maryland Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a 6012 Terrell Ave. 20745 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ZYes 2 2 No WWII
If Yes, Give
Yeer or Detes: Korean War Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Records Maintenance Officer Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Charles Anthony Dondero Mary Ellen Carey 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) mportant: if Item 27 noy injury or other to Ernest M. Bailey/Husband Same as item 10 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete Maryland Veteran's Cemetery 1/11/2000 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Boneral Service Licensee 22. Name and Address of Fecility
George P. Kalas Funeral Home, P.A. also 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner pert horson sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequence of) EMPHYSOMA physician s the buria Box 68760. Physician/Medical Due to (or as e consequence of) esn P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably Unknown Records, þ 24b. Were autopsy tindings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 00 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 10 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Mennes of Death 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 DiNeturel r death. 1 Yes 2 No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 0 To the Hospital of within 24 hours a To the Funeral C completely filled edical 29a. Certifier (Check only one) 29b. Signaturilland fittle of ogtifier 29c. License number 29d. Dete signed (Month, Day, Year) Jary 30. Name and address of payor who completed ceuse of deeth (Item 23a) (Type, Print) M.D. Yazdani, 11418 Livingston Rd. Ft. Washington, Md. 20744 Arastoo 31. Date filed (Month, Day, Your) 32. Registrar's Signeture State JAN 0-6 2000 Registrar

DHMH 16 Rev 6/95

JAN 5 8 2000 Johnson A. Marte

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	4 December 11 Mary 17 To 18 Mary 18 Ma	State of Marylar		tificate of		1	Reg. No.	J	2 Time of Danie
Physician /Medical	Decedent's Name (First, Middle, Last RUTH ALICE	BRYANT				Jan. 2	, 28°00	Year	3. Time of Death 4:45 am
Examiner Funeral Director	5/9-40-0839		last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi	Princ	e Geo	orge lace (State or Foreign try) Ington D.C
and and	Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	cation				11	Od. Inside City Limits
a Mary affect affect ofor	Maryland Prince G	eorge Hya	ttsvill	e					1 ☐ Yes 2√ No
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?			try?
ours after death with the Maryland rail, or hams 23e or 23e-f show Examiner must be notified at 1 by Funeral Director	5805 Forty Second 11. Maritel Sielus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give 1 Year or Dates:		20781 Vas Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	U.S.A. icity Yes or No- Rican, etc.) 14. Race - America Black, White, et Specify: Whit		etc.
d 2 should be filed within 72 hours after th and Mental Hygienu. T is meritaid other than "natural", or his traumetic event, the Medical Examina To Be Completed by Fu	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of work d)	ing	16b. Kind of Bu	usiness/Inc	
at other seem, if	17. Father's Name (First, Middle, Last) James O. Pier		School	or bus Di	18. Mother's Name		, Maiden Suman		
should by marked marked armatic ar	19a. Informant's Name/Reletionship (7)	rpe, Print)	19b. Mallin	g Address (Stree	t and Number or Run			State, Zip	Code)
	John S.E. Bryant	(son)			e Dr. Hyat	tsvill	e, Md. 2	20784	
semit. Pages 1 at Separament of Hea reportant: if hem iny injury or other ance.	20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cemetery, cren	sition (Name of matory or other pla In Cemete		Date /6/2000	20c. Location - Brentw		
permit Depart Importa	21. Signature of Funeral Service Vicens) 22	. Name and Addre	oce of Engility		In Funer		
requires that the death certificate be assecuted with the death certificate be assecuted with the death certificate by the attending physician and hould be detached for use as the burial-transit and hould be detached for use as the burial-transit and hould be detached for use as the burial-transit and hould be detached for use as the burial-transit and the following the followi	23a. Part 1. Enter the disease, or compishock, or heart failure. List only of limits of the control of the cont	Due to (oxia or as a conseq or as a conseq or as a conseq	uence of): 'C' uence of):					Onset and Death
at the death certific d by the attending petached for use as		d				-146			
that the death certification that the death certification of the attending of detached for use as a Physician/Me	Part II. Other eignificant conditions con Diabetes Mellit		sulting in the ur	nderlying cause gi	ven in Part I.		tobecco use co Yes 2⊠ No		the cause of death?
Was aw							s an autopsy ormed?	CO	ere autopsy findings allable prior to mpletion of cause death?
cate has com						10	Yes 2 No	10	Yes 2 No
Physician: This certificate and director, part of the Co. To Be Co.	25. Wes case referred to medical examiner?	lospital:] ED/O-4	4 2 DO: O	26. Place of Deat her:			ne (0===*	ia)
To the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. Medical Certification: To Be Com	27. Manner of Death t Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Hursing Fix		idence 6 □Oth how injury occur		γ)
tal or Attanding P in after death. al Director: After ted in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office			(Street and Numl own, State)	ber or Rura	I Route Number,
To the Hospital or I within 24 hours after To the Funeral Dire completely filled in I Medical Certi	(Check only 2 Medical Example one)	nician: To the best of my known for: On the basis of examination and manner stated.		restigation, in my	opinion, death occur		, date and place,	and due to	the cause(s)
To the To the Common	29b. Signeture and title of certifier			29c. Licen			29d. Date signe		
	30 Name armeditioned parent parent	D00081 January 6, 2000							.000
State Registrar	David Anders, M. 31. Date filed (Month, Day, Year) JAN 0 6 2000	D. 8824 Cunni 32. Registrers Sign	ngham I			leights	, Md. 20	740	

DHMH 16 Rav 6/95

38H 0 5 2000 James 12 Serveter

Plea

se Type or Print in Black Indelible Ink. Assure	All Copies Are Legible.	
State of Maryland / Department of Health an	d Mental Hygien 0 0	444
Certificate of Death	Reg. No.	
e, Last)	2. Date of Death Month Day Year	3. Time of

Physi /Med Exam

Funer Directo

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hybjens. Important it flem 27 is mental offer than 7 is mental offer than "natural", or herm 23e or 23e 4 show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medica Examine

To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Department Name /Clear Adidate			Ce	rtificate	of Death	7	Reg	. No.		
I. Decedent's Name (First, Middle	, Last)					2	. Date of Death Month	Day	Year	3. Time of Death
FLOYD H. BULL	S JR.						Month JANUARY	2,200	00	4:04am
la Facility Name (If not institution	, give street and number	r)			4b. City, T	own, or Loca	ition of Death	4c. County	of Death	
HOLY CROSS HOS	PITAL					VER SI	PRING	MONTO	GOMERY	
5. Sociel Security Number 579-18-0080	6. Sex 100 M 2 F		last birthday, 8 Yrs.	Months D	ear If Unde ays Hours	Min.	Date of Birth (Month, Day,) OCT 23,	1921		INGTON
Jsuei Residence of Decedent										
Oa. State 10b. County			y, Town or Lo	TON DC					10d	Inside City Lim
0e. Street and Number				10f. Zip Co					What Country	n
1218 45th PLAC					20019			_	STATES	In the s
1. Marital Status 1. Never Married	12. Was Deceden Armed Forces 1 Tyes 2 Till Yes, Give Yeer or Detes	?] No		Was Decedent if Yes, specify 1 ☐ Yes 2 🛣			ty Yes or No- can, etc.)	Blac	e - American ck, White, etc y: BLAC	
15. Decedent (Specify only highes			16a. Dece (Give	dent's Usuai O kind of work d DO NOT use n	ccupation one during mo	st of working	16	ib. Kind of B	usiness/Indus	stry
Elementery/Secondary (0-12)	College (1-4or	5+)		ESTAT				PRIV	ATE	
17. Father's Name (First, Middle,	Last)		10211	- DOINE			First, Middle, Ma			
FLOYD H. BULLS							WORMLEY		100	
19a. informant's Name/Reletions	nip (Type, Print)		19b. Maili	ng Address (Si			Route Number, (State, Zip Co	ode)
ANN BULLS / WI	FE		1218	3 45th	PLACE W	ASHING	GTON DC	20019		
Oa. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp.		9 0	emetery, cre	osition (Name of matory or other CTION CI	r place)	1-6		LINTO	City or Town	n, State
21. Signature of Funeral Service							FUNERAL			
23a. Part1. Enter the disease, or shock, or heert feilure. List	Oim.	mon					FORESTVI		D 2074	7
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events	b	Due to (o	r as a conse	quence of):						
cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	r as a consec	quence of):						
Part ii. Other significant conditio	d	but not resi	ulting in the u	inderlying caus	e given in Pert	1.	23b. Did tob	acco use co	ntribute to th	he cause of dea
GANGRENE, PER	IFERAL VASC	ULAR	DISEAS	SE			1 🗆 Yes	2 ₩ No	3 Probal	bly 4 Unknown
							24a. Was an performe	autopsy ed?	24b. Were availe comp of de	autopsy finding able prior to bletion of cause ath?
							1 ☐ Yes	XXNo	10	res 2□ No
25. Was case referred to medical					26 Plac	e of Death /	Check only one			
axaminer? 1 ☐ Yes 2X No	Hospital: Winpat	ient oП	ER/Outpatie	nt 3 DOA	Othor	ursing Home			net (Snecity)	
27. Manner of Death 1 XX etural 5 Pending 2 Accident investig	28a. Date of inj (Month, D		28b. Time of Injury		Injury at Work?	28	d. Describe how			
3 Suicide 6 Could r 4 Homicide determi	ned 200. Place of Ir	njury - At ho	ome, farm, st	reet, factory, of	fice	28	l. Location (Stre City or Town,	et and Numb State)	ber or Rural F	Route Number,
29e. Certifier 1 Certifying	Physician: To the best examiner: On the basis of and manner s	of examine	wiedge, deat lion and/or in	h occurred at the vestigation, in	ne time, date a my opinion, de	nd place, an ath occurred	d due to the cau l at the time, dat	se(s) and me and place,	anner as state and due to th	ed. ne cause(s)
(Check only 2 Medical I			^	29c. Li	cense number		290	t. Date signe	d (Month, Da	y, Year)
(Check only 2 Medical	20 0.040	01.	. 1							
one) 2 Medical I	Vell	em	W		D42578			IANUAR	Y 2.20	00
one) 2 Medical I	Uncertainty of the completed cause of	deeth (Item	1 23a) (Type,	Print)	D42578		J	IANUAR'	Y 2,20	00

DHMH 16 Rev 6/95

Mary Drug Cross of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Marylar		ificate of			Reg. No.	01445
Physician /Medical	1. Decedent's Name (First, Middla, Las BURFORD L.	BAILEY				2. Dete of De Month	Day	2000 101 20 PW
Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or L Lanham	ocation of Deat		of Death e George's
Funeral Director	Doctors Communit 5. Social Security Number 223-40-5433 1			If Under 1 Yaar Months Days		8. Date of Bir (Month, Di		9. Birthplaca (Stata or Foraign Country) Virginia
2 .	Usual Rasidance of Decedant 10a. State 10b. County	10c C	ity, Town or Loca	tion		-		10d. Inside City Limits
Maryle 4 sho field at for	Maryland Prince G		andover					1 X Yas 2 No
th with the Ma 23e or 28e+* aut be notified	10e. Street and Number 3206 - 81st Aver	ıue		10f. Zip Code 2078	85		10g. Citizen of V	
020 urs after death v air, or thems 23a Exempler, meat by Funeral		12. Wes Decedant Ever in L Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates:		as Decedent of H res, specify Cuba Yas 2 🖾 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, atc.)	5 14. Race Blace Specify	e - American Indian, kk, Whita, atc. Black
121215-0020 and within 72 hours at Spiere, we than 'natural', or at the Medical Exam Completed by F	15. Decedent's Ed (Specify only highast grant Etementery/Secondary (0-12)	ucation da completed) College (1-4or 5+)			oation during most of work d) Superviso		16b. Kind of Bu	isiness/Industry
	11 th 17. Fathar's Nema (First, Middla, Last)		Demo	71101011	18. Mothar's Nam			
Aland the file when the week	Burford A. Ba	iley			Annie	K. Wr	ight	
Aary Carbo	19a. Informent's Name/Relationship (7				and Number or Rui			
Foam 27	Annie E. Bailey		J2Ub = 8 Place of Disposit cematary, crama		nue, Land			ZU/OD City or Town, Stata
More, Pages 1 a	1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify		cematary, crama armony M		-	01 7 08 2000		er, Maryland
Balti Barmit Departm Importa any inju	21. Signatura of Funeral Sarvice Licen		22. I J.	Nama and Addra B. JENK	INS FUNER	AL HOME		yland 20785
ct	23a. Part1. Entar tha disease, or companies, or haert feilura. List only	plicetions that caused the daa	th. Do not entar	tha mode of dyir	ng, such as cardiac	or raspiratory a	rrest,	Approximata Interval Between
Physician /Medical Examiner	Immediate Cause (Final disaasa or condition rasulting in daath)		AGE L	27111	eal cr	PRCIN	oma	Onsat and Death MONTHS
death certificate be executed eathending physician and dor use as the burial-transit siclan/Medical Examiner	Sequentially list conditions, if any, leading to immadiata causa. Entar Undartying Cause, (Disease or Injury that initiated evants rasulting in death) Last	с	or as a conseque					
O. B. the death the atternation for the digital of	Part II. Other significant conditions co	ontributing to death but not ra-	sulting in tha und	erlying cause giv	ven in Pert I.	23b. Did	tobacco use cor	ntribute to the cause of death?
Ph dby	CHRONIC RET	TAL FAILLY	RE			10	Yes 2□No	3 Probably 4 Unknown
Cord v require been si should	IDOM					24e. Wes	an eutopsy ormed?	24b. Wera autopsy findings available prior to completion of cause of death?
il Rei The lav ate has page 2	PSEUDOMONE	B TRACHI	MS			10	Yes 2006	1 ☐ Yes 2 ☐ No
	25. Was casa referred to medical axaminer?				26. Place of Deal	h (Check only	ona)	
of Vita Physician: This certific rel director,	1 Yas 2 No		28b. Time of	3 DOA Oth	4 LI Nursing Ho		idenca 6 Oth-	
After fune	4 Natural 5 Panding 2 Accidant invastigation	28a. Data of tnjury (Month, Day Year)	Injury	28c. Injui Wor M 1 □	rk? Yas 2□No	280. Describe	now injury occur	90
Division crass and a state death: an a sheet death: led in by the tunera Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, atc. (Speci	noma, ferm, atree	t, factory, office		28f. Location City or To	(Street and Numb wn, Stata)	er or Rurel Route Number,
Division to the Hospital or Attention within 24 hours after deal completely filled in by the Medical Certifical		yalclan: To the best of my kno iner: On the basis of examine end menner steted.						
W Carlot	29b. Signature and title of certifier			29c. Licens	se number		29d. Data signed	(Month, Day, Year)
(na)	19-3	300		D	16410		1/7	100
29	30. Nama and addrass of person who of GABRIEL JARE	MD 7500	O HAD	int) OVER T	PKWY #	105,6	REENE	ELT, MD 20776
State Registrar	31. Data filed (Month, Day, Year) JAN 0 7 2000	32, Registrar's Sign	A.	pals		,		

DHMH 16 Rev 6/95

de la la constitución

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 01116

		,	Certificate of Death	Reg. No.							
17	Dhusisian	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year 3. Time of Death							
	Physician /Medical	Wayne Maurice Bishop	J	Jan. 5, 2000 7:25 am							
1	Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Locat								
1	1	Southern Maryland Hospital									
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b 42	Yrs. Months Days Hours Min. S	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Wash. D.C.							
	D Bu	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits							
	Mery to	Md. Prince Georges Fo	restville	X□ Yes 2□ No							
	ifer death with the Marylan r flams 23s or 28s f show ning mat be notited at Funeral Director	10e. Street and Number 8204 Fernham Lane	101. Zip Code 2 0 7 4 7	10g. Citizen of What Country? U.S.A.							
21215-0020	by B	11. Marital Status 1 □ Never Married 2 □ XMarried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricc 1 ☐ Yes 2X No Specify:	y Yes or No- lan, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black							
5-0	ed within 72 ho yglene. wr then "natura ft, ms treated Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry							
121	within the same	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)								
2	offied within if Hygiens. other than vent, me to	17. Father's Name (First, Middle, Last)	Special Policeman	Georgetown UNiv.							
an	d be flied that Hyg sed other c event,	William Bishop		icille Howard							
Maryland	end Mental Hygle end Mental Hygle e marked other eumatic event, To Be Co		b. Mailing Address (Street and Number or Rural R								
	127 pd	Sandra L.Bishop Wife 8	3204 Fernham Lane Fo	prestville,Md.20747							
Baltimore,	T He Y	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of the Control of Contr	Date 20c. Location · City or Town, State Cheltenham, Md.							
Balti	pemit. Peg Depertment Important: f eny injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hur. 908 Kennedy St.N.	nt Funeral Home							
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart lailure. List only one cause on each line.									
	Physician /Medical Examiner	Immediata Ceuse (Final disease or condition resulting in death) a. Employer as a Due to for as a	1 1	Cances 3 Months							
	executed in and fel-traneit Examiner	b	a consequence of):								
ó	ificate be executed gibhysicien and set the burlei-traneit ledical Examin	if any, leading to immediate	consequence ory:								
68760,	cate be physicia the bu	Cause (Disease or injury C.	consequence of):								
	* O										
Вох	thend or us	d									
P.O.	that the deeth cert ed by the ettending deteched for use ? Physician/M	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yea 2 10 3 Probably 4 Unknown							
	by by	House Proportion	9 1220013 20 200	I an III an III							
Records,	D 20 %			24a. Was an autopsy performed? 24b. Wera autopsy lindings available prior to completion of cause of death?							
	The late he page			1 Yes 2 No 1 Yes 2 No							
Vitai	certificate rector, pag	25. Was case referred to medical axaminer?	26. Place of Death (C	Check only one)							
of	T digital	1 Ves 2 No Hospital: 1 Unipatient 2 ER/C		5 Residence 6 Other (Specify)							
LC.	h. After funer funer	1 Natural 5 Pending (Month, Day Year)	. Time of linjury at Work? 1	d. Describe how injury occurred							
5	deat deat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospi 14 hou Funer (sky fill	29a. Certifier (Check only one) 1 ① Certifying Physician: To the best of my knowledge (Check only one)	pe, death occurred at the time, date and place, and ind/or investigation, in my opinion, death occurred in the course of the cou	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)							
	within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
		Sam Tellalle	1 13421	4 1.5,2000.							
	0	30. Name and address of person who completed cause of death (flem 23a SAM TE//AW 1 M.D. 7503 2	(Type, Print) SURRATIS RD, CLINITO	ON, MD. 20735							
ı	State	31. Dale filed (Month, Day, Year) 32. Registrar's Signature	4								

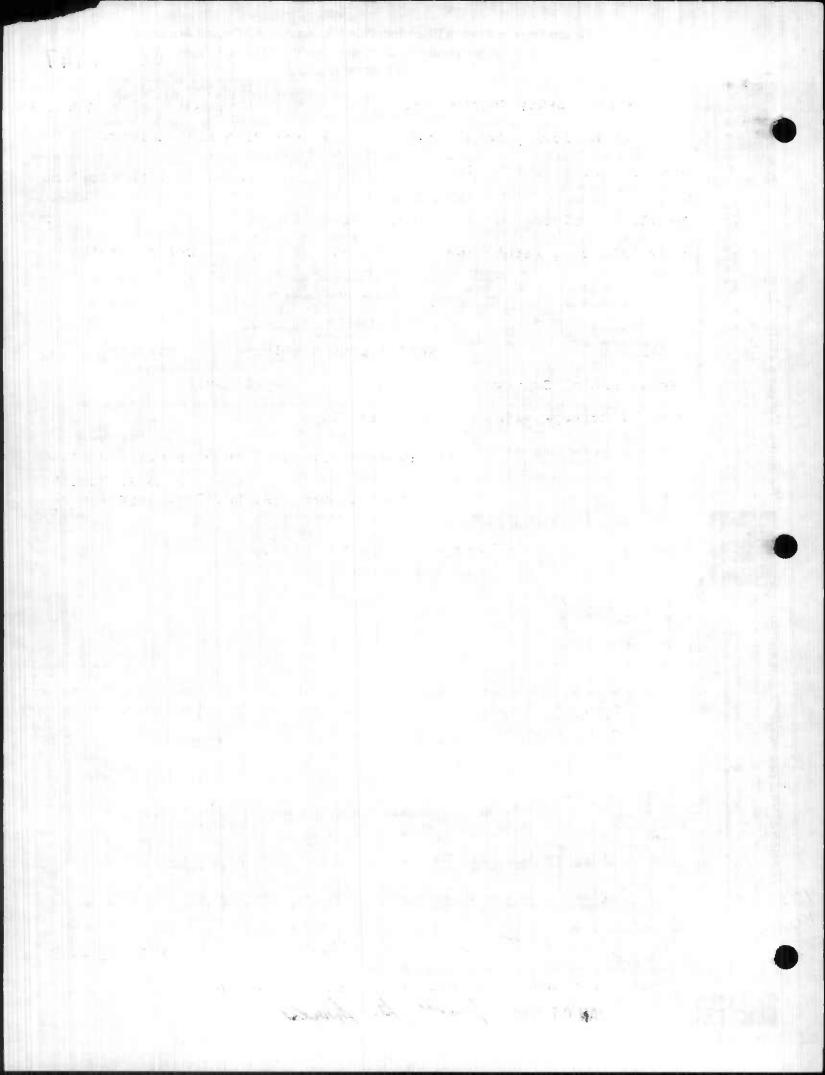
DHMH 16 Ray 6/95

2000 F 0 MAL State State

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1447

				Certifica	ie oi L	ealli		Reg. No.		144./		
	1. Decedent's Name (First, Middle, La						2. Date of D Month	eeth Day	Yeer	3. Time of Death		
Physician /Medical	WOOD COT HO		y, Sr	•			Janua	ry 5 2	000	12:37 PM		
Examiner	4a Facility Neme (If not institution, given 5442 Hallow		t Road		Pı	rince		ick Cal	vert			
Funeral Director	220 16 4621	7. Age 7. Age 7.	In yrs. lest birt	rrs. If Und Month	er 1 Year S Days	if Under 24 Hr Hours Mir	. (Month, E					
pue M.	Usuai Residence of Decedent 10a. Stete 10b. County		Oc. City, Town	or Location					10	d. inside City Limits		
the Meryler 7 28a-f show notified	Maryland Calve	ert	Prin	ce Fr		.ck				1 ☐ Yes 2☐ No		
th with	10a. Street and Number 5442 Hallowing	Point Ro	ad	2	0 6 7 8			United		•		
ors effer frames by Fur	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 12 Yes 2 □ No if Yes, Give Year or Dates:	er in U,S.			panic Origin? (, Mexicen, Pue Specify:	Specify Yes or N rto Rican, etc.)		e - America ck, White, e whit	itc.		
c	15. Decedent's E (Specify only highest gn	ducetion ede completed) College (1-4or 5+)			rork done du use retired)	ion ring most of w		16b. Kind of B	usiness/ind	ustry		
e filed al Hygid other vent, b	17. Father's Neme (First, Middle, Last)		F	-			e, Meiden Sumer				
should be fill marked out imatic ever		Copsey				Ma	mie Su	it				
nd 2 selfth ar 27 le	19a. Informant's Name/Relationship (Meiling Addre	** * -	nd Number or E	Rurel Route Num	ber, City or Town	Stete, Zip	Code)		
8 6 2 2	20e. Method of Disposition 1X Buriai 2 Cremation 3 4 Donetion 5 Other (Special		cemeter	Disposition (A y, cremetory of	other plece		7 2000	20c. Location				
pemit. Pag Department Important: I any injury o	21. Signature of Funeral Service Lice	1500			and Address			h Funer Port Re				
Physician /Medical Examiner Examiner Examiner	immediate Ceuse (Finel disease or condition resulting in death)	b	ue to (or as a c	Consequence of	Ŋ:	Lui	v G					
ng physicia es the bur	Ceuse (Disease or Injury that Initiated events resulting in death) Last	c		onsequence of								
etter for u	Part il. Other significant conditions of	contribution to death but	not resulting in	the underlying	cause dive	n in Part I	23h Die	d tobacco usa co	ntributs to	the cause of death?		
that the ed by the deteche	Ceub	ti m			_		15	Yes 2 No		ably 4 ☐ Unknown		
The law requires that cate has been signed by page 2 should be del Completed by P	Dabe	li ro	Whi				24a. Wa	s en eutopsy formed?	ava	re eutopsy findings illeble prior to appletion of cause leath?		
The law ate has page 2							10	Yes all No	10	Yes 2000		
ysician: The is certificate director, pag	25. Wes cese referred to medical exeminer?	All Code !			101		eeth (Check only	one)				
hys his	1□ Yes 2E(No	Hospital:		tpetient 3 !!		4 Unursing	-	sidence 6 Otl)		
After fune fune fune	2 Accident Suicide Could not be			njury M		es 2 No		(Street end Num		I Doute Number		
40 the Hospital or Attention within 24 hours effect deal To the Funeral Director: completely filled in by the Medical Certifical	4 HomicIde determined	28e. Piace of injury building, etc.	(Specify)	rm, street, tact	огу, опісв		City or T	own, Stele)	oer or nure.	House Number,		
Ne Hospital nn 24 hours Ne Funerel pletely filled	29a. Certifier 1 Certifying Pt (Check only one) 2 Msdlcai Example 1	nysician: To the best of niner: On the basis of e end menner state	xamination and									
Me Me		J. C	7	2	9c. License	number		29d. Dete signe	d (Month, L	Day, Year)		
3,70	1 pm	sattur	/		D2543	35		Januar	у 6,	2000		
	30. Name and address of person who	completed cause of dee	th (item 23e) (Type, Print)								
	Mukesh N. Mat.	h	D			1	00655					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death CANNADY Month trude 8:25AM 2.000 4b. City, Town, or Location of Death 4c. County of Death BAltimore Baltimore If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number If Undar 1 Yaar 8. Data of Birth (Month, Day, Birthplaca (Stata or Foreign Country) Days Min. 10 M STAF Hours 237 22 7671 96 Virginia Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Durham Durham XXYas 2 No 10a. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 1301 N Hyde Park 27701 usa 12. Was Dacedanf Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarlcen Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Specify: black 1 ☐ Yas 2 ENNo XXWidowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) private duty Nurse's aide 12 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Lousinda Jake Chappell (unk) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) John Cannady 707 Stumford Rd Baltimore Md 21229 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1-6-00 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Spacify) Durham NC 27707 Markham Memorial Gardens 21. Signature of Funeral Service Licensee NC-FSL 22. Nama and Addrass of Facility 27701 354 Durham NC Ellis D Jones & Sons 419 Dowd St artt. Enlier the disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, hook, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting In daath) Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initiated avants rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performad? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Department from the service of the s

Physician

/Medical

Examiner

NC

Director

Funeral

ρ

Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Manylan neart of Haatih and Mental thyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic avent, the Medical Exterimet must be notified at

Maryland 21215-0020

Baltimore,

Physician/Medical Examiner for usa by Completed pege 2 Be Certification: To

this certificate

after deeth

within 24 hours a To the Funeral C

Hospital or Attanding Physician:

ş

1 Yas 2 No

2 Accident

4 - Homicida

3 Suicida

29a. Cartifian

25. Was casa rafarrad to medical axaminar? 27. Mangar of Death 1 Natural

29b. Signature analytitle of certifiar

5 Panding Invastigation

6 Could not be datarminad

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how Injury occurred

1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa numbar

29d. Data signad (Month, Day, Year)

30. Name and address of person who completed ceusa of death (Itam 23a) (Type, Print)

Cator Ave. Baltimore, MD.

26. Placa of Death (Check only ona)

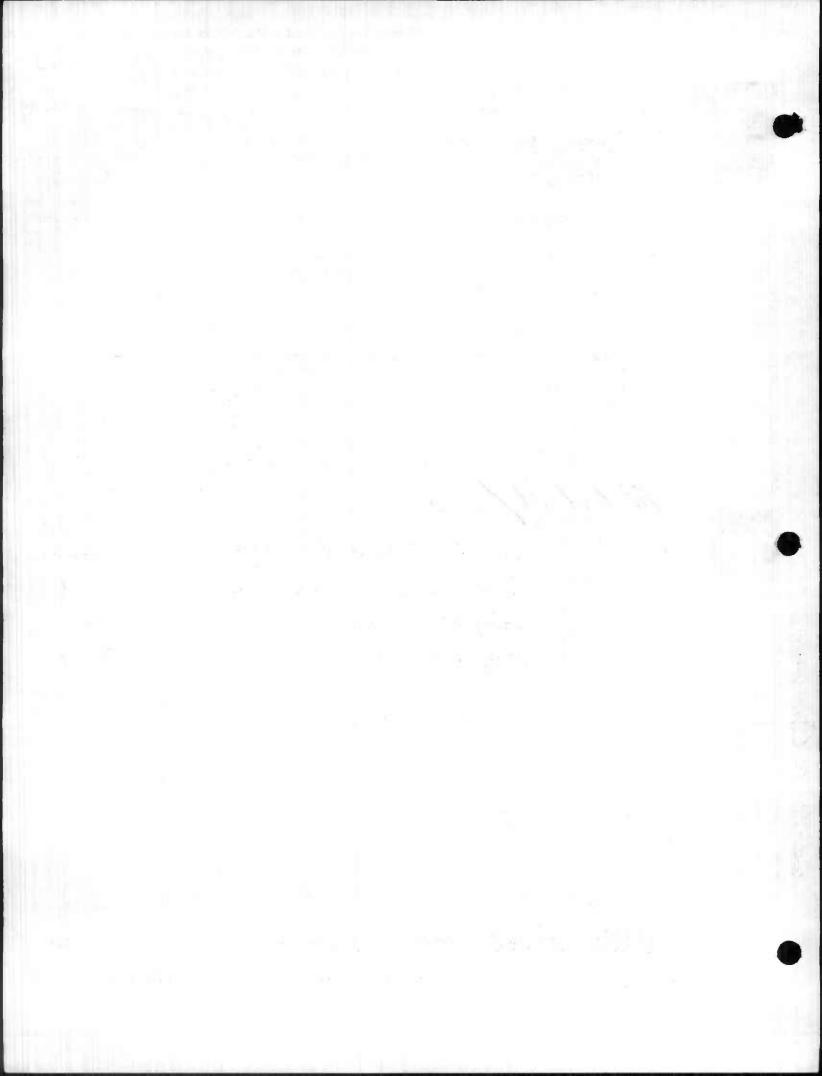
2000

State Registrar

Medical

31. Data filad (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10

					i y i ai i				Death	a mornar r	Reg. No.	U U	1449		
	Physic /Medi		1. Decedant's Nama (First, Middle, L Sulamita M.							2. Data of I Month Jan	Daath Dey	Yaar 2000	3. Time of Death 5:35 AM		
	Exami		4a. Fecility Nema (If not institution, g	iva street and numbe	ır)				4b. City, Town,	or Location of Dec			5 10 5 111		
1			Pikesville Nurs	ing Center					Pik	esville	В	altimo	ore		
	Funeral Director		5. Social Security Number 6. 223-12-8206 Usual Rasidence of Dacadant	Sax 7. / 1□ M 2☑ F	Aga (In yrs. I	ast birthday) Yrs.	if Undar Months	1 Yaar Days	If Undar 24 H Hours M	lin. (Month, I	Sirth Day, Year) 30 1899	9. Birthple Count Braz	ace (State or Foreigr ry) zil		
	Maryland H show	tor	10a. Stata 10b. County	imore	100	, Town or Lo						10	d. Insida City Limits		
	r 28s	Director	10e. Straat and Number				10f. Zip	Coda			10g. Citizan of	What Count	ry?		
	h with	a D	7 Sudbrook Lane					21	208		United	State	28		
020	72 hours after death with the Maryland 'natural', or frems 23s or 28a-f show edical Examiner must be notified at	by Funeral	11. Manital Status 1 □ Navar Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad	12. Was Decedar Armed Forca: 1 Yas 25 If Yes, Give Yeer or Datas	s? ₹No		Was Deced If Yas, spec			(Specify Yas or Nerto Rican, atc.)	Specify Yas or No- to Rican, atc.) 14. Race - A Bleck, V Specify:				
5-0	72 ho	etec	15. Decedant's I (Specify only highast g			16a. Dece	dant's Usua	l Occup	ation during most of a	working	16b. Kind of B	usiness/Indu	ustry		
21215-0020	yiene.	Completed	Elamantary/Secondary (0-12)	Collage (1-4o	r 5+)		nemake		d)	NOTKING	Own	Home			
Maryland	should be filed and Mental Hygis marked other	To Be	17. Fathar's Nama <i>(First, Middl</i> a, Las Theodore	martins						Nama <i>(First, Midd</i> a DaMott	(First, Middla, Meiden Surnama) DaMotta				
lan	sh end		19e. Informant's Name/Raletionship	(Type, Print)		19b. Maili	ng Addrass	(Straat	and Number or	Rural Routa Num	ber, City or Town,	Steta, Zip (Code)		
	E TO W		Fr. William A. C	ollins s	son	953	33 Lib	ert	y Road	Randal1	stown, M	D 211	133		
Baltimore,	permit. Pages f and Department of Healt Important: If Item 2 any Injury or other ODCE.		20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Othar (Spec		a CE	aca of Dispo matary, crar 1y Fan	matory or or	har pla	•	Deta 1/6/200	20c. Location				
	Physician /Medical Examiner		25h Pant . Entar tha disaasa, or co hock, or haart failura. List onl Immediata Cause (Finel disaasa or condition rasulting in daath)	nplications that cauly one cause on a se	roscl	. Do not ant	1212 W tar tha mode	a of dylr	ld Libe	rty Road diac or respiretory	rectors, Winfie arrast,	ld, MI	Approximate Interval Batween Onset end Death		
ox 68760,	eath certificete be executed attending physician and for use es the buriel-transit	Physician/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	b		es a conseq as a conseq									
$\mathbf{\omega}$	death e atter	sicia	Part II. Other significant conditions	contribution to death	hut not resu	Iting In the u	ndarlying cs	uso ah	en in Part I	23h Di	d tobacco usa co	ntribute to	the causa of death?		
s, P.O.	the ach	by Phys					nounying or	adae gir	diriiri dice.		Yes 2 No				
ecord	aw requires been so should	Completed b									s an autopsy formed?	com	ra autopsy findings leble prior to apletion of cause eeth?		
al B	E se g			T						10	Yas 2 No	10	Yes 22 No		
Vital	Physician: The this certificate ral director, peg	Be	25. Was casa refarred to medical axaminar?	Hospital:				Oth		Death (Chack only					
of	Phys ral di	on: To	1 Yas 2 No 27. Manner of Deeth 1 Natural 5 Pending	1 ☐ Inpa 28a. Data of In (Month, D	jury	P/Outpatier 28b. Tima of Injury		A Bc. Injur	4 12 Nursing		sidance 6 Oth how Injury occur)		
Division	Attend r death octor: by the	Certification:	2 Accidant invastigation 3 Sulcida 6 Could not determine	on 28a. Place of I		me, farm, str	М	10	Yas 2□No		(Straat and Numb own, Stete)	er or Rural	Routa Number,		
	despitation of the control of the co	icai Ce	29e. Certifiar 1 Certifying P	hyalcian: To the bes minar: On tha basis	t of my know	rledge, daath	occurred a	it the tir	ne, data and pla	aca, and due to the	e causa(s) and ma	nner as sta	ited.		

State Registrar

Dobarah I Plan 31. Date filed (Month, Dey, Year) JAN 0 5 2000

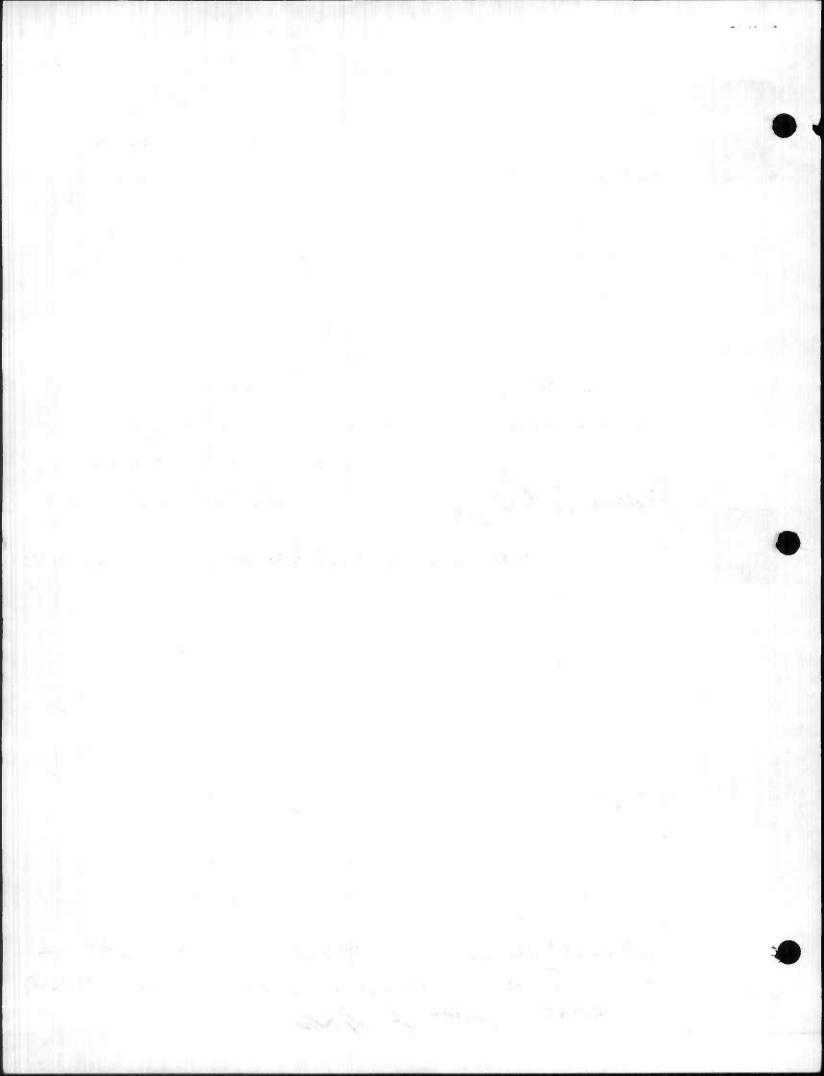
29b. Signatura and title of certifian

kights Avenue Baltimoro MD2128

29c. Licansa number

H45931

29d. Data signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

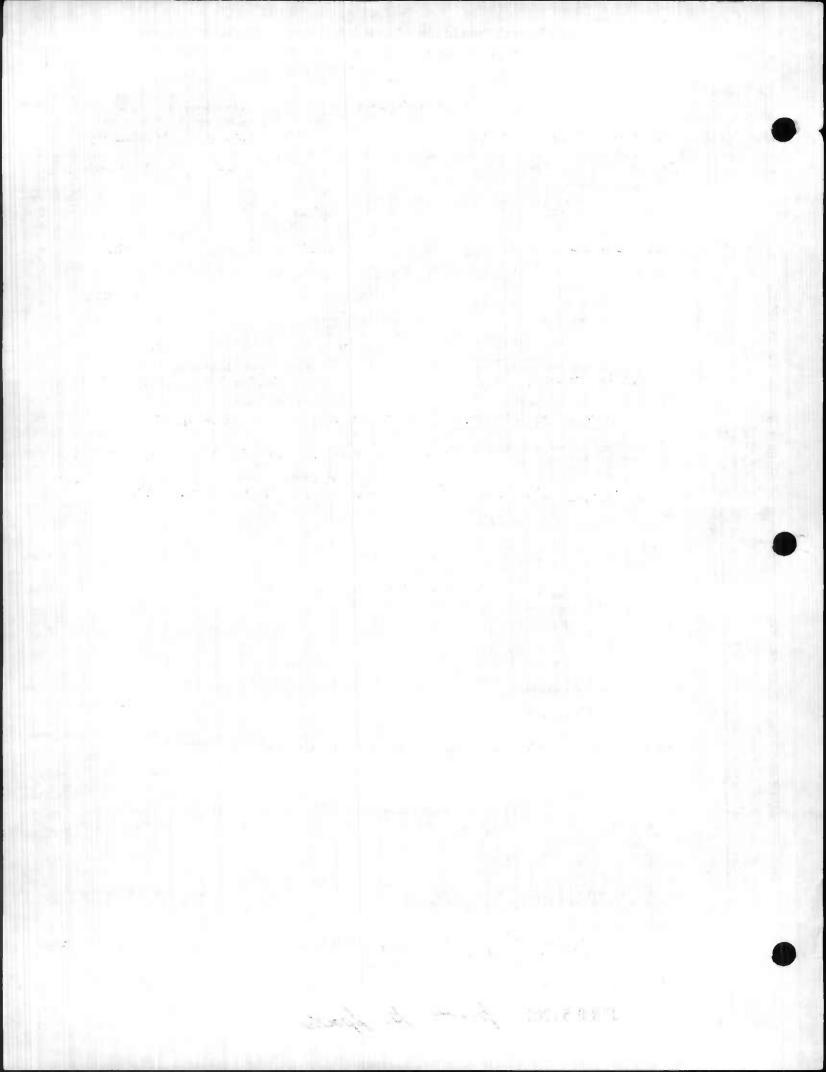
					State of Ma	aryland		artment of I	Health and N Death	Mental Hy	giene ()	0	0145	0
		. 1	1. Decedant's Nam	a (First, Middle, La	st)					2. Data of De	ath	Maria	3. Time of De	eath
ı	Physici /Medic		RUTH	V.	DRYDEN	CHE	RIX			Januar	y 1, 200	Year 00	11:10	AM
	Examir		4a. Facility Nama (f	f not institution, giv	re street end numbar)				4b. City, Town, or L	ocation of Deat	h 4c. County	of Daath		
					& Rehabil				Snow Hill					
в	Funeral		5. Social Security N	1	Sex 7. Ag I□M 2□XF		est birthday) Yrs.	If Undar 1 Year Months Days		8. Data of Bir (Month, De	v. Year)		iaca (Stata or F	Foreign
	Director		213-01-75 Usual Rasidance of			94	110.			June 1	2, 1905	Mar	yland	
	yland		10e. Steta	10b. County		10c. City	Town or Lo	cation				1	0d. Insida City	Limits
	Mar Drad	ctor	MD	Worceste	er	S	now H	ill					Yas 2	!□ No
	or 28	Director	10e. Street and Nur	nber				10f. Zip Coda			10g. Citizen of V	/hat Coun	try?	
	9th w	rail	5803 Eve	ergreen 1	1			21863			USA			
	er de	Funeral	11. Maritel Status		12. Was Decedant Armed Forcas?		S. 13. V	Was Decedant of f Yes, specify Cut	Hispanic Origin? (Sp ben, Maxican, Puerto	pecify Yas or No Rican, atc.)	14. Reci Biac	e - Amaric k, Whita,		
020	d within 72 hours after death with the Manyand jene. r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	by F	1 ☐ Never Marri 3 🖾 Widowad	ed 2 Married	1 ☐ Yas 2 ☑ If Yas, Giva Yeer or Datas:	No	,	1□Yas 2ŒNo	Specify:		Specify	· wh	ite	
21215-0020	72 hou naturs			15. Decedant's Ed	ducation		16a. Deced	dent's Usuei Occu	pation		16b. Kind of Bu			
215	within 7 ene. then "n	ple	(Spec	ndary (0-12)	ada com <i>plated)</i> Collega (1-4or 5	i+)	(Giva Iifa. L	kind of work done DO NOT use retire	during most of work ed)	king				
2	filed with Hygiene. ther ther	Completed	9				Seamst	ress			Clothi	ng		
Maryland	0 = 0 =	Be	17. Fathar's Name ()				18. Mothar's Nam		, Ma <i>id</i> an Sumem	Θ)		
7	d Mentel	٦	Edgar Dry		T 0		400 1400	A.1	Sally Mo					
Ma	d 2 sl th and 7 is n		19a. Informant's Na		grandson)				Dr., Snow				Code)	
	Heal Heal tem 2 other		20e. Method of Disp		grandson	20b. Pic	aca of Dispo	sition (Nema of		Data	20c. Location -	-	wn, Stata	
OIL.	Pages nent of h ant: If ite ury or of			☐ Cramation 3 ☐ 5 ☐ Other (Specification)	Ramovai from Stete			netory or other pla	Cemetery 1	///2000				1
Baltimore,	# P P P		21. Signatura of Fu		nsaa		22	. Nama end Addr	ess of Fecility				aryrand	
Ö	Depar Important Ir		Minis	K. DA	Desmo	1129		_	Melson Fr				1051	
			23a. Pert1. Enter th	na disaasa, or com	plicetions that caused ona causa on each iir	tha death.	Do not anti	ar tha moda of dy	en Ave., I	or raspiratory a	rrest,		Approximata Interval Between	
Я	Physician		orrown, or readi	t tallara. Clot of hy									Onset and Dec	eth
И	/Medical Examiner		fmmediata Causa (disaase or condition rasulting in daath)		a Jep	312						i		
		Ē	radating in datiny		2011	Dua to (or	as a conseq	juance of):	CHF, I	1,000		1		
	uted J Insit	Examiner			b. Deur	run	1	STI	CHFI	1110				
o`	tificate be executed g physician end ss the burial-transit	Exa	Sequentially list cor if any, leading to im cause. Enter Unde	nditions, imadieta irlving	4. 1	Dua to (or	as a conseq	Dance or):	CR. T	25		1		l,
68760,	ite be ysicie	edicai	Cause (Disease or that initiated evants resulting in death) L	injury	c. Typ	Dua to for	as e conseq	uance of):	1	/				
	ng ph		rasuming in deam) t	.ast				-	ŕ			i		
Box	thet the daeth certified by the attending detached for use and	Physician/M			d									
P.O.		ysic	Part II. Other eignifi	cant conditions o	ontributing to death be	ut not rasul	ting In the ur	ndarlying causa gi	ivan in Part I.	23b. Dld	tobacco use cor	itribute to	the cause of c	death?
	law requires thet the as been signed by th		OT	feopor	ors, O	ad thi	Thi.	Deh	y drath.	10	Yee 2□ No	3 Prot	bably 4 Sun	known
ds	w requires that been signed t should be det	d by		0,	0.					24a Was	an autopsy	24b. Wa	ara autopsy find	dings
00	shour	lete		Do very	randos	2'				perfo	rmed?	ava	allable prior to mpletion of cause death?	
Re	icien: The lav certificate has rector, page 2	Completed								10	Yas 2500		Yas 20 No	0
ta	ysicism: The la is certificate ha director, page	Be C	25. Was casa rafarr	ed to medical					26. Placa of Dear		/		2100 2011	-
<u>></u>	5 00	10	axaminar? 1 ☐ Yes 2 ☐	No	Hospital: 1 Inpatia	nt 2 E	R/Outpatien	t 3 DOA Ot	thar: 45 Oursing Ho	ome 5 🗆 Resi	dance 6 Oth	ar (Specif)	y)	
o L	ding Phys h. After this funeral d		27. Manner of Death	5 ☐ Panding	28a. Data of Injur (Month, Da)	y Year)	28b. Tima of Injury	Wo	ork?	28d. Dascribe	how Injury occurr	ed		
Sio	death death ctor: A y the f	cati	2 Accident 3 ☐ Suicida	invastigation	Α]Yes 2□No					
Division of Vital Records,	or At after of Direction by	ertification:	4 Homicida	datarmined	28a. Piace of Inju- building, atd	ury - At hor :. (Specify)	ne, farm, str	eet, factory, office		City or To	Street and Numb wn, Stata)	er or Rura	I Route Number	H,
_	spital cours refilled	O	29a, Cartifiar	Certifying Ph	yefcian: To the best o	of my know	iedga, daath	occurred at the ti	ima data and place	and due to the	cause(s) and ma	nnar as si	tated	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only one)	2□ Medical Exam	niner: On the basis of and manner sta	axaminatio	on and/or inv	astigation, in my	opinion, daath occur	red at tha tima,	data and place, a	and dua to	tha cause(s)	
	withii To th	×	29b. Signature end	titia of certifiar	Merr	J.			se number		29d. Data signed	(Month, I	Day, Year)	
	1			10	TOV CAN I			2-1	305445	12	1/1/	20	40	
	6				complated causa of de	aath (Itam :	23a) (Type, I	Print)	4 . 2		1/1/ ke,	MI	0218	251
	-01		31. Data filed (Mont	h. Dav. Year)	32. Registre	r's Signati	ITA	u (M	1/0	como	ne,		. 0	
	Sta Registra			AN 0 5 20		ar s Signati	G.	Spark	1					

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 011, 51

					Certifi	cate o	f Death)	Re	g. No.		140	
Physician	1. Decedent's Nama (First, M		(00 -				2. Data of Death Month	Day	Year	3. Time of	
/Medical		BUR		Jewe !	JJE C		4h Cihi Ti	own orla	Docation of Death	4c. County	O O O	3 =	PAM
Examiner	4a Facility Nama (If not institu Manor Care N	Jursing C	enter				Silv	ver S	Spring	Mont	gomer		
Funeral Director	5. Social Security Number 579–10–1366	6. Sax 1(X)M 2□		in yrs. lest birt		Undar 1 Ya onths Day		Min.	8. Data of Birth (Month, Day, NOV 23	1913	9. Birthpl Count V1rc	laca (Stata d trx) Jinia	or Foreign
pue »	Usual Residence of Decedant 10e. State 10b. Cou		1	Oc. City, Town	n or Locatio	n					10	0d. Inside C	City Limits
vith the Marylar to 28a-f show be northed at Director	MD Ho	ward				Da	ayton					1 🗆 Yas	2 X 1No
	10e. Street and Number 4966 Mornings	star Driv	e		10	Of, Zip Code 21	036		10	Og. Citizen of \	USA	lry?	
- F 4 1	11. Marital Status 1 Navar Marriad 2 3 Widowed 4 Divor	Married 1 H Ya	Decedant Eved Forcas? Yas 2 XNo as, Giva	ar in U,S.	- 40	Decedant of specify C			ecify Yas or No- Rican, atc.)		e - Amarica ck, Whita, a v: Whi	atc.	
5-00 rs hours hature	15. Dece	dant's Education	intad)	16a.	Decedant's	Usual Occ	cupation	et of work	ing	16b. Kind of Bi	usinass/Ind	lustry	
vithin within than than omple	Elamantary/Secondary (0-1		ega (1-4or 5+)			chan	na during mos ired) LC	SI OI WOIK	"ig	Auto	motiv	<i>7</i> e	
ind be file tal Hy dothe	17. Father's Nama (First, Mide William C		pbell				18. Moth		a (First, Middla, M Le Lois				
E N	19a. Informant's Name/Raiati Mrs. Barbara								al Routa Numbar,			Coda)	
OF THE PART OF THE	20a. Mathod of Disposition 1 Durial 2 Cramati 4 Donation 5 Otha		from Stata	20b. Place of cematar	Disposition	n (Nama of ry or othar p	olace)	1	7	20c. Location -	City or To		. MD
Baltim pemit. Pag Department Important: I any Injury o	21. Signatura of Funaral Sarv		lains	ef	²² Na	me and Ad GHT	dress of Facil	HOM	E & CHAI	PEL. PA	(Box		
	23a. Part1. Entar tha disaasa	, or complications	that can ed th	a daath. Do r			-				100	Approxima	
Physician	shock, or haart failura.	List only ona cause	a on aach lina.									Onset and	Death
/Medical Examiner	Immadiata Causa (Final disaasa or condition rasulting in daath)	a		EUM.								1 4	SEX.
Je Je			,	a to (or as a c	consaquant		2					14	San
axecuted in and ital-transit	Sequentially list conditions,	Б		ua to (or as a									
cords, P.O. Box 68760, requires that the death certificate be axecuted seen signed by the attending physician and hould be deteched for use as the buriat-transit eted by Physician/Medicai Examir	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaase or injury that initiated events rasulting in death) Last	c	Du	a to (or as a c	consequanc	e of):							
Box atth certificant certification is a second certification in the certification is a second certification in the certification in the certification is a second certification in the certification in the certification is a second certification in the certification in the certification is a second certification in the certi		d											
P.O. at the d by the letached Physic	Part II. Other significant cond			not rasulting in	n tha undari	lying causa	givan in Part	l.		bacco use co		the causa bably 4	
Di 2 s p	CHRONIC	0857	noct(vs P	y cma	TNAL	Orss	Z267	24a. Was a perform	n autopsy nad?	ave co:	ara autopsy allabla prior mpletion of daath?	to
The The Com									1 □ Ya	s 2 No	10	Yas 25	3 No
of Vital I Physician: The rubs certificate and director, pages n: To Be Co	25. Was casa rafarred to mad axaminar?	licel Hospital:					Other		th (Check only on				
Of V Physic rithis co	1 Yas 2 No			2 ER/Ou	tpatient 3	L DOA	njury at Nork?	lursing Ho	oma 5 Raside			V)	
Sing After tune tune	1 DNatural 5 Pa 2 Accident inv	astigation	Data of Injury (Month, Day)		njury N	VI 1	Yas 2]No	28f. Location (St			I Poute Atu	mhar
Divi	4 ☐ HomicIda dat	arminad 28a.	Place of Injury building, atc.	(Specify)	ım, straat,	tactory, offi	ce		City or Town	n, Stata)	yer or Hura	7 Floure Wor	noer,
Divisi To the Hospital or Attentivities 4 hours after deat To the Funeral Director: completely filled in by the		fying Physician: T cal Examiner: On and		xamination and									(s)
To th To th comp	29b. Signatura and title of cer	480	2	_	m 0		ansa number	7	2	9d. Data signe	id (Month,	Day, Year)	055
	30. Nama and addrass of pers	son who complated	d ceusa of daa			1)			0.5	10~00	20	707	
State	31. Data filed (Month, Day, Yo		32. Registrar	S Signatura	1793	2 1	BOUTIN	1025	- CANE	SAUR	R, A	לואפור	MAD
Registrar	JAN 0	5 2000	Ben	wa	Ø.	Spa	uls.						-



Edward Cropper 21416 4815

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** EDWARD JAMES CROPPER occition of Death
RIIRY

4c. County of Death
WICOMICO /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 15M 20 F Yrs. Director 214-16-4815 VA 5/22/19 Usual Residence of Deceden the Marylan 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 84 Scottsdale Park flams 23s USA 12. Wes Decedent Ever in U,S. Armed Forces?

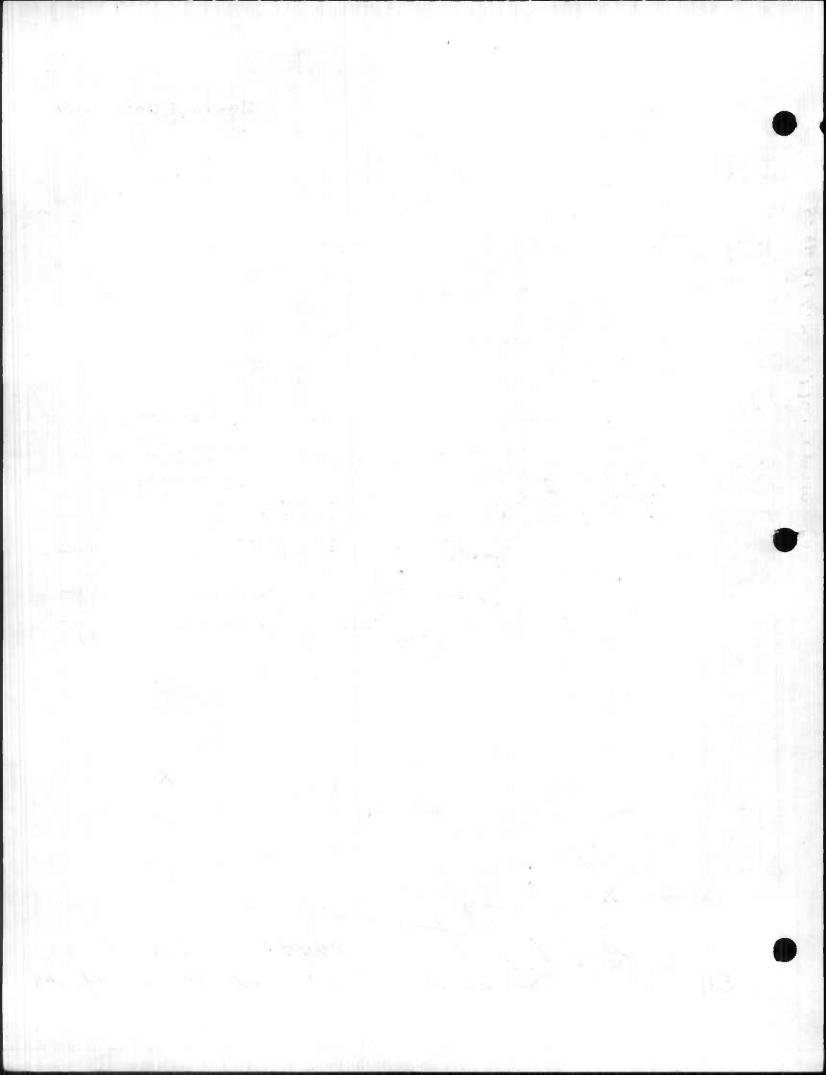
1XE Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 'natural', or WWII white 1 Yes 2 XNo Specify: ğ 3℃(Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Wher then 'n Elementary/Secondary (0-12) College (1-4or 5+) Sea food Waterman 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked off Maryann Powell John William Cropper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7409 Gumboro RD Apt.302 Pittsville, MD 21850 Mona Glenn/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete important: If It any injury or o 1 Denial 2 Cremation 3 Removal from State 1/12/00 Libertytown, MD Riverside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD 21811 untal ny disease, or complications by caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, trailure-List only one cause of each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. 0 (to eaneup USA AS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown ò 24a. Was an autopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death? Completed page 2 1 20 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes PDNG 1 | Inpatient 2 | ER/Outpatient 30 DOA SHI 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural or Attending 5 Pending investigation 1 Yes 2 No 24 hours after deeth. Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Fune completely fi (Check only 29b. Signature and this bi 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 400 E shore Or SALISBURY, Raffelto oseph 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Day 2000 Month **Physician** 12, JAN. 1:12PM JOSEPH ANDREW CAMPBELL /Medical 4e. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5209 RED HILL DRIVE PISGAH CHARLES If Under 1 Yaar if Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthpiace (State or Foreign Country) **Funeral** 1₩ 2□ F Months Yrs. Director 219-16-0014 74 MAY 10, 1925 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "netural", or items 23a or 28a-f show traumetic avant, the Modical Examinat must be notified at 1 Yas 20 No Director MARYLAND CHARLES PISGAH 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5209 RED HILL DRIVE 20640 UNITED STATES death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iter any Injury or other traumetic avant, the Medical Exercises. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2Ñ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th FOREMAN FEDERAL GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumema) RICHARD CAMPBELL MARY V. CURTIS CAMPBELL DENT ဥ 19e. informant'e Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) JULIA CAMPBELL / WIFE 5209 RED HILL DRIVE PISGAH, MARYLAND 20640 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) VETERANS CEMETERY 1/19/00 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility THORNTON FUNERAL HOME, P.A. LYDIA C. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 THORNTON JOHNSON MO0583 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Betw Onset and Deeth **Physician** cordiorespirolog arrest-/Medical tmmediate Ceuse (Finel disease or condition resulting in deeth) Examiner retastate Prestate concer Examiner **bunal-transit** be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last and physician s the buria Box 68760, Physician/Medical Dua to (or as a consequenca of): signed by the atte Records. P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 No 3 | Probably 4 | Unknown by 24e. Wes en autopsy performed? 24b. Wera autopsy findings svallable prior to Completed completion of cause of death? page 2 has 1 Yes 2 No certificate 1 Yes 2 No Division of Vital Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) Hospitei: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this funeral 28a. Dete of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Maturel 24 hours after death.

Puneral Director: After 1 Yes 2 No 2 Accident filled in by tha 3 Suicide 8 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the tima, deta and place, and due to tha cause(s) end menner stated. edicai 29a. Certifier To the 29b. Signeture end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D31675-13 gan 2000 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) lain reduced center white Plains 20 20695 Lhite 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State JAN 1 3 2000 doords) Registrar



DHMH 16 Rav 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time f th **Physician** Anna LUOLO 11:291 Jan. 01 00 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince George Hours Min. 8. Data of Birth (Month, Day, Year) 6. Se If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** 10 M 20 F Months Days 94 216 50 9170 Yrs. Director July 15,1905 Italy Usual Rasidence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits MD P.G. 1 ☐ Yes X ☐ No Director Hill Crest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "naturel", or itama 23a or the Medical Examiner must be a 20748 United States 1914 Gaither Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a and highly or other traumatic avent, the Medical Examiner mass and. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, etc. Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 8th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) Concetto Cansornella Salvatore Jimmle Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Altemus (GRANDDAUGHTER) 706 Quince Orchard Blvd, #102, Gaithersburg, MD 20a. Method of Disposition
1 X Burial 2 Carcemation 3 □ Removal from State 20b. Place of Disposition (Name of Jan 6, 2000) ate 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facilities Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. pproximate terval Between nset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) Ileus Days Examiner Due to (or as a consequence of): Physician/Medical Examiner Months Persistent Diarrhea g physicien end as the burial-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) NS8 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Hypertension, Ostebarthritis, by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Wes en autopsy performed? Completed Thalassemia minor, Atherosclerosis 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending Investigation 1 DE Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 6 24 hours el Funeral D letely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the F Within 2 To the F complete Signature and the of cartifler Purily, DO 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. Licanse number MD HOOY 2445 01 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Pimentel, DO

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2000

601 POST OFFICE ROAD, 1-A WALDORF, MD 32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #23B PER PHY State of Maryland 2 Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** 2000 LIRIA ILISCUPIDEZ JAN /Medical CABANATAN 11:00 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** BETHESUA

| H Undar 1 Year | H Undar 24 Hrs. | 8. Date of Birth
| Months | Days | Hours | Min. | Month, Day, Year)
| May 14,1926 NATIONAL NAVAL MEDICAL CENTER MONTGOMERY 5. Social Security Number 9. Birthplace (Stata or Foraign County)
Philippine. Is. 7. Aga (In yrs. last birthday) **Funeral** Months 1□M 2♥F 73 564-56-3289 Director Usuai Rasidance of Decedant deeth with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ir than "natural", or items 23a or 28a-f show the Medical Experimen must be notified at Washington, D.C. ty Yas 2 □ No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 20032 177 Chesapeake St. S.W. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 2 0 No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 14. Race - Amarican Indian, Biack, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours effer Department of Haaith and Mental Hygiena. Important: if Nem 27 is marked other than "natural", or Nem any injury or other traumatic event, the Medical Exaction once. 1 Never Married 2 Married Specify: Asian Filipino Baltimore, Maryland 21215-0020 1 Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collaga (1-4or 5+) 12th At Home Homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Ismaela DeGuzman P Vicente Iliscupidez 19a. tnformant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Valeriano T. Cabanatan/Husband 177 Chesapeake St., S.W., Washington, DC 20032 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data tXXBuriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 1/12/2000 Arlington, VA George P. Kalas Funeral Home, P.A. ! Kalas 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Cause (Finel disaasa or condition resulting In death) /Medical CHRONIC OESTRUCTIVE PULMONARY DISEASE Examiner Dua to (or es a consequence of): Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Lest Dua to (or es a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably- 4 Unknown þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Houpital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifical 25. Was case rafarred to medical axaminar? 8 26. Pleca of Death (Check only one) Hospital: 1

☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 ☐ Yas 2 ☑ No funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturei 2 Accidant 5 Panding 1 Yas 2 No invastigation 8 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledga, daath occurred at tha tima, dete and place, and dua to the causa(s) and mannar as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the causa(s) and mannar stated. 29a. Cartifier Medical (Check only one) 24 To the 1 within 2 To the i 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) aguil n. Punaryo, MO MD - 30545 (DC) 01,03,00 30. Nama and addrass of person who complated ceusa of death (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA_MD_20889-5600 RAYMOND M. PUMAREJO, CDR, MC, USN 31. Data filed (Month, Day, Year)
JAN 0 5 2000 32, Registrar's Signatura State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2000 3:30 p.m. Jan. Edward C. Cale Sr. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not Institution, give street end number) Prince Georges Rirtholece (State or Foreign 5505 Ruxton Dr. Lanham If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece Country) tXXM 2□ F Months Deys Hours Min Yrs 240-24-5124 Sept 28 1922 North Carolina Usuel Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5505 Ruxton Dr. 20706 U.S.A. 14. Rece - American Indien. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2☐(No Specify Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondery (0-12) College (1-4or 5+) 12 years Proof Reader G.P.O. 18. Mother's Nama (First, Middle, Maidan Surnama) 17. Father's Neme (First, Middle, Last) Charlie E. Cale Lula Bridges 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Edward C. Cale Jr. - Son 20706 5505 Ruxton Dr. Lanham, 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Jan 8. 1 ☐ Buriei 2 Cremetion 3 ☐ Removei from Stete Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria, VA 2000 21. Signature of Fuheral Service Licenses 22. Neme end Address of Fecility Rendon/Hale Funeral Home 20706 Approximata intarvai Between Onset and Deeth 9013 Annapolis Rd. Lanham, MD the mode of dying, such as cardiac or respiratory errest. Immediate Ceuse (Fine) diseese or condition resulting in death) Due to (or es a consequence of) Dua to (or as e consequança of): Partill. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

Physician /Medical Lagranger

physician and the burial-transit

as USB

signed t

page 2 hes

funeral director,

certificate

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifici

24 hours e

completely To the Within 2

P.O. Box 68760

Division of Vital Records.

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Funeral

Director

Repentit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene.

Theorient: If item 27 is marked other than "natural" any four or other traumatic averages.

Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Ceuse (Diseese or Injury that initiated events resulting in daeth) Last

24b. Were autopsy findings availeble prior to completion of cause 24e. Wes en eutopsy of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending invastigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, offica building, atc. (Specify) 4 Homicide

29a. Cartifier Certifying Physician: To tha best of my knowladga, daath occurred at the time, date end pieca, end due to the ceuse(s) and manner as stated.

Medical Examinar: On the besis of examination end/or invastigation, in my opinion, daath occurred at the tima, data end piace, and dua to tha cause(s) and manner stated. 29b. Signeture and 29d. Dete signed (Month, Dey, Year) 29c. License number

1. Dete filed (Month, Dey, Year)

Mo plated causa of death (Item 23e) (Type, Print) 9500 Arrapolis os

State Registra

2000



ans

DHMH 16 Rev 6/95

JAH C 8 2500 Summer A. London

pro-grade a state of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 1:08 AM AN 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner COLUMBEA OWARD (renera HOSPNAL Hunder 24 Hrs. 8. Dete of Birth Hours Min. March 28, If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months 10M 20 F Washington, D.C. 579-48-2508 66 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show Examiner must be notified at 1 XYes 2 □ No Prince George's Maryland Seat Pleasant 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? D 6302 Carrington Court 20743 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify à natural'. 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 12th permit. Pages 1 and 2 should be filk Department of Health and Mental Hy important: If them 27 Ia marked other any Injury or other traumatic evant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Ford Ermma Carter 0 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Leroy R. Cheek, Sr./Husband 6302 Carrington Court, Seat Pleasant, Maryland 20743 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State 01710 ery, cremetory or other place) 1 Burial 2 □ Cremetion 3 □ Removal from State Maryland Veterans Cemetery 2000 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility
J.B. JENKINS FUNERAL HOME Nancy Perce 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Finel /Medical NEUMONIA disease or condition resulting in death) Examiner rephalopathi The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical 88 signed by the a P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No Records, þ Be Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 Yes 2 No death. Investigation 2 Accident 24 hours after deal Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only one)

within 2

5

Registrar

Dey, Year) 0 5 2000 0

29b. Signeture and title of certified

10724 6. YVE 32. Begistrer's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

twent Parloway Columbia MODIOUS

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 10:50 m /Medical 4b. City, Town, or Location of Death 4c County of Death 4e Fecility Neme (If not institution, give street end number) Examiner 12/ r 24 Hrs. If Under -6. Sex (5. Social Security Number 7. Age (In yrs. last bighday) 9. Birthplaca (State or Foreign Country) **Funeral** Months Davs Hours XM SDF Yrs 220-26-4383 68 Director Jan 10, 1931 Washington DC Usuel Rasidenca of Decedant death with the Meryland 10a Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 Yes XIX No Funeral Director 288-1 P.G. Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 9115 Marlboro Pike #26 234 20772 United States Nema 2 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yas X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementery/Secondery (0-12) 7th College (1-4or 5+) Automobile Technician Automotive Baltimore, Maryland 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Peges 1 and 2 should be facent of Health and Mental int: if item 27 is marked of William Howe Cook Ethel May Bryant 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Idelle Cook (WIFE) 9115 Marlboro Pike, #26, Upper Marlboro, MD 20772 other 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Crametion 3 Ramoval from Stete 6 Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Jan 10, 2000 Clinton, Maryland 22. Neme end Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signalure of Funeral Service Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760, physician Physician/Medical the Due to (or e signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaceo use contributs to the cause of death? P.O. 1 1488 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? NIA 2 No 2 No certificate 1 Yas To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, in the f 25. Was case reterred to medical axaminar?
1 Yes 2 No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 (DNaturei 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and little of cortific 29c. License number 29d. Dete-signed (Month, Dey, Year) 10 4467012 30. Nama and address of person who complete d cause of death (I)em 23a) (Type, Print) OBAMMA 31. Date filed (Month, Dey, Year) 32. Registra s Signetura State JAN 0 7 2000

DHMH 16 Rev 6/95

Registrar

194 - 1960 STAGE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middla, Last) 2. Data of Deeth 3,2000 Month **Physician** DECATUR В. HARVEY 0500 am January /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) AUG. 11,1921 9. Birthplace (Stata or Foreign Country)
WASHINGTON, DC 8. Sex 1D M 2□ F **Funeral** Hours Months Days 577-22-8376 78 Yrs. Director Usual Rasidance of Decedent death with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director MARYLAND CALVERT LUSBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be 812 GOLDEN WEST WAY 20657 U. S. A. Funeral Nema 2 Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. was becedent Ever in U.S. Armed Forces? totyas 2 □ No ff Yes, Give Vear or Dates: W.W.II Bleck, White, atc. ed other than "natural", or iter event, the Medical Examiner filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) BAIL BONDSMAN BAIL BONDS 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental THEODORE DECATUR MABEL MC CULLOUGH 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) if item 27 is 4150 BRISTOL DRIVE CHESAPEAKE BEACH, MD PAMELA SCHMIDT / DAUGHTER other t 20732 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurial 2 Cremetion 3 Removal from Stata JAN. Department of Important: If any injury or ò MARYLAND VETS. CEMETERY CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 7,2000 22. Nama and Addrass of Facility LEE FUNERAL HOME CALVERT, P.A. 21. Signature of Funaral Service License 8125 SOUTHERN MARYLAND BLVD. OWINGS, MD 20736 23a. Print. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Fibrais /Medical Immediata Causa (Final diseesa or condition rasulting in daath) movonu Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last and Dua to (or as a consequence of): Box 68760, Due to (or as a consequence of): P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown þ of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate has 2000 1 ☐ Yas 1 □ Yas 2 □ No apital or Attending Physician: Thours after death.

neral Director: After this certificate filled in by the funeral director, pa 25. Was casa refarred to medical examinar? Medical Certification: To Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Enpatient 2 ER/Outpatient 3 DOA 1 | Yas 2 2000 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 Balatural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicida To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, deta and place, and due to the cause(s) and manner stated. 29a. Cartifiar completaly (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 00255 2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 20678 16+1 PRINCE FREDERICK, MD JOSEPH BARTH, MD,

DHMH 16 Rav 6/95

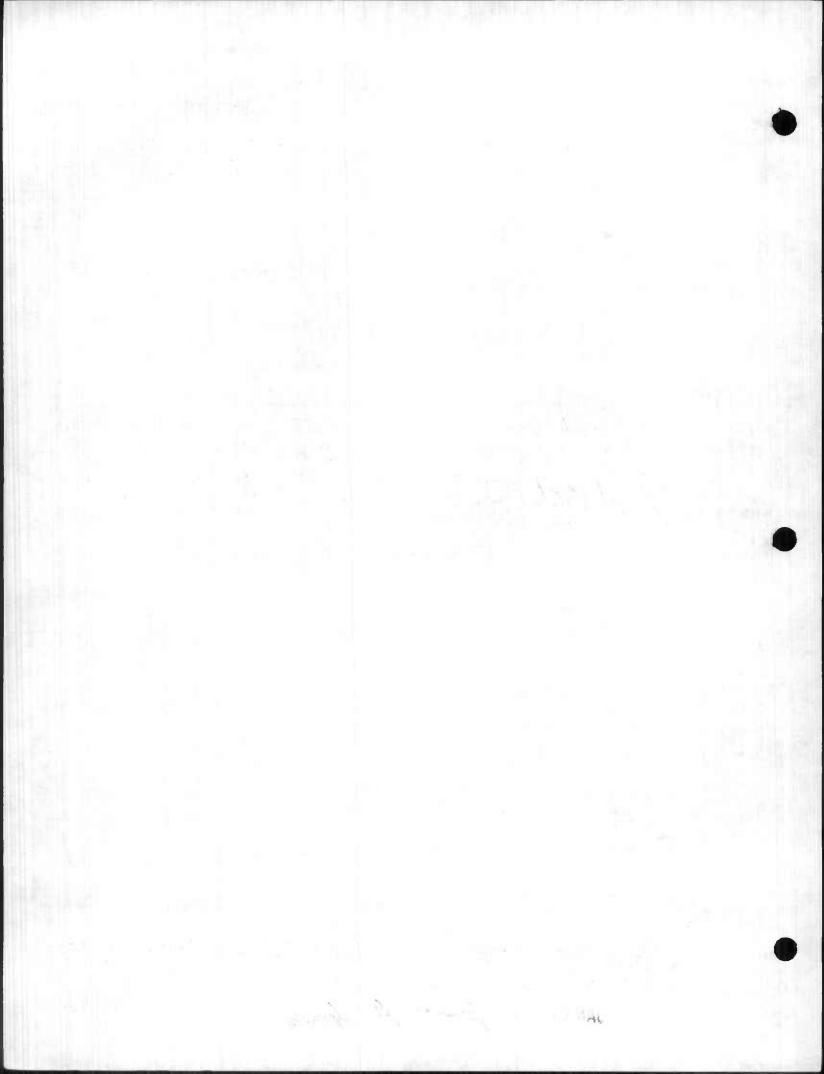
State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signatura

JAN 0 6 2000 D



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Carl Hammond Davis, Sr. 17:40 01 00 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Carroll County General Hospital Carroll Westminster 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpleca (Steta or Foreign Country) 1⊠M 2□ F 73 Yrs. 16, 1926 South Carolina 250-32-3642 Usuel Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21771 United States 2613 Gillis Road 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Reca - American Indian, Black, Whita, etc. IXIYes 2 □ No If Yes, Give Yaar or Dates: WWII 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorcad White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Social Security 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Daisy Hammond Wesley Davis 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Bessie A. Davis Wife 2613 Gillis Road Mt. Airy, MD 20b. Pleca of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) All County Cremation, Inc. 1/2/00 Sykesville, Maryland re of Funeral Service Licen 22. Name and Addrass of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 To not enter the mode of dying, such as cardiac or raspiratory arrest, the diseesa, or complications that caused the disease. List only one cause on each line. Approximate Interval Between Onsat and Deeth Immediate Cause (Fine diseesa or condition resulting in death) Due to (or es e consequenca of):

Physician /Medical Examiner

the burial-transit

page 2 should be

The law requires that the death certificate be executed

or Attending Physician:

the Hospital 24 hours To the Hosp within 24 hou To the Fune completely fi

s eftar deeth. filled in by

Division of Vital Records, P.O. Box 68760,

Department of Important: If any Injury or

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after on ant of Health and Mental Hygiene.
Int: If Hem 27 Ia marked other than "natural", or ites iry or other traumatic event, the Medical Examination.

Baltimore, Maryland 21215-0020

Director

by Funeral

Completed

Be

deeth with the Marylend

lan/Medicai Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated events rasulting in deeth) Lest Due to (or es a consequence of):

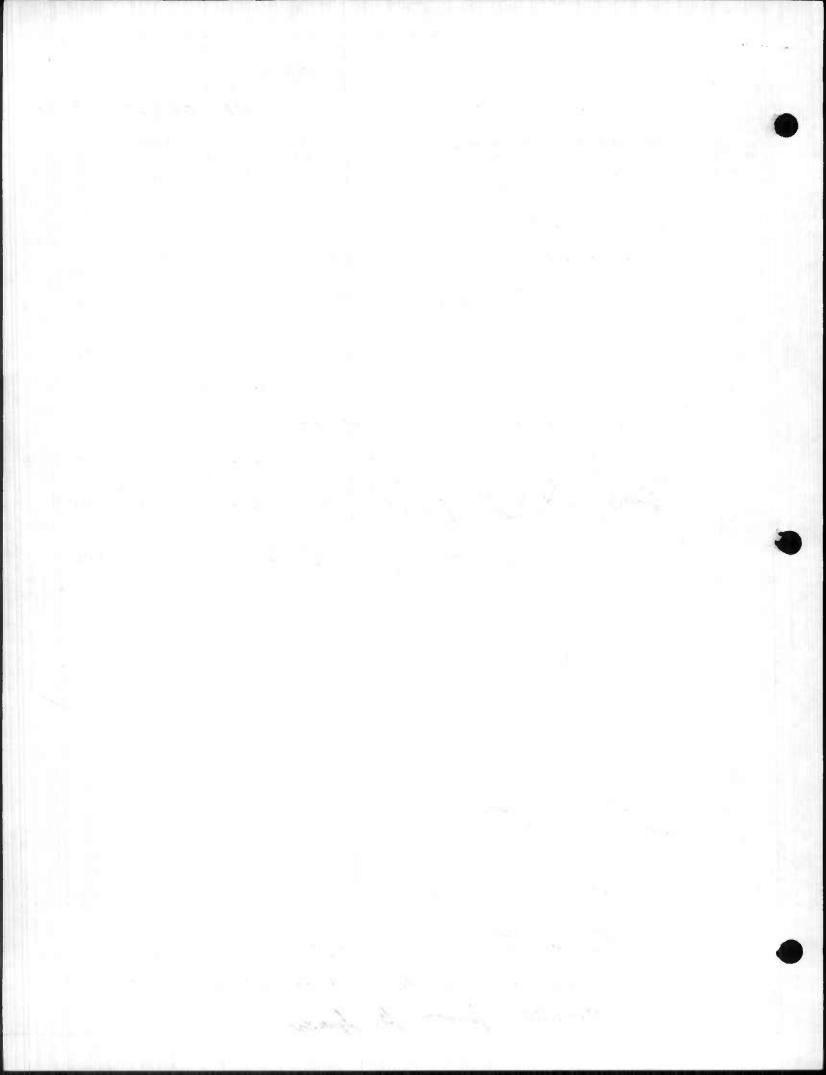
Pert II. Other significent conditions of	ontributing to deeth but not re		23b. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknow						
				24a. Wes en eutopsy performed?	24b. Were eutopsy findings evallable prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical	26. Place of Deeth (Check only one)								
examiner?	Hospital:	☐ ER/Outpatient 3☐							
27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigetion		28b. Time of injury	28c. Injury et Work?	irred					
3 Sulcide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	nome, ferm, straet, fect	ory, office	28f. Location (Street end Num City or Town, State)	ber or Rural Route Number,				
29a. Certifier (Check only one)	ysician: To the best of my kn ninar: On the basis of examin- end manner steted.	owledge, deeth occurre ation end/or investigation	ed et the time, date end plecon, in my opinion, deeth occ	ce, end due to the cause(s) end m curred et the time, date and pleca	nennar es stated. , and due to the cause(s)				
29b. Signature end title of	111	2	9c. Licensa number	29d. Dete sign	ed (Month, Day, Year)				

State Registrar

31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 1, 2000 Nora Marie Davis January 3:54 pm 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 15, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1□M 2X F Months Days Hours Min. Yrs. 1927 Washington, DC 578-34-0665 72 Usual Residence of Decadent 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3545 Madison Street 20783 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Naver Marriad 2 Marriad 1 ☐ Yas 2 ☒ No Specify: If Yas, Give Year or Dates: White 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Computer Technician U.S. Government 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Patrick Joseph Fleming Nora Reidy 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Richard Davis - Husband 3545 Madison Place, Hyattsville, MD 20783 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cramation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/06/00 Silver Spring, MD 22. Name and Addrass of Facility
Gasch's Funeral Home, P.A. 21 Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 avac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onaet and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case rafarred to madical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

must be notified at

r than "natural", or items the Medical Examiner m

Director

Funeral

Àq

Completed

Be

death with the Maryland

filed within 72 hours efter

Hygiena.

. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 Is marked other th jury or other traumatic event, in

permit. Page Department of Important: If any injury or once.

Baltimore,

P.O. Box 68760.

Division of Vital Records,

Examiner Physician/Medical

þ Completed Be To Certification:

ician and burial-trans physician sthe burial 88 attending USB Por been signed by the a should be detached pege 2 has certificate funeral director, this After

after death. filled in by

Hospital or Attending Physician: 24 hours a To the Hosp within 24 hou To the Fune completely fil State

31. Date filed (Month, Dey, Year)

JAN 0 4 2000

29b. Signature and title of certifier

30. Nama and addrass of person

Jason Casey M

27. Manner of Death

1 Naturai 2 Accident

3 Suicide

29a. Certifier

edical

4 Homicide

5 Panding

invastigation 6 Could not be datemined

28a. Date of Injury (Month, Dey Year)

D34526

28c. injury at Work?

29c. License number

1 Yes 2 No

15 Cartifying Physician: To the bast of my knowledga, death occurred at the tima, date and place, and dua to the causa(s) and manner as ateted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner ateted. 29d. Date signed (Month, Day, Year) .1.00

Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

ted cause of death (Item 23a) (Type, Print)

5268 Dawes Avenue, Alexandria, Virginia

32. Registrar's Signature

28b. Tima of

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

Registrar

The same of the sa

to the state of the state of

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** MILDRED INEZ DEMMA /Medical 4a Facility Name (If not institution, give street and number) Examiner Charles County Nursing Home LaPlata If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 M 2 F 577-62-1390 93 Director Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the itemical Exempler must be notified at Maryland Charles Waldorf Director

2. Date of Death 3. Time of Death Month 11 3:28 AM January 2000 4b. City, Town, or Location of Death 4c. County of Death Charles 8. Date of Birth (Month, Day, Year)
June 26,1906 Birthplace (State or Foreign Country) Maryland 10d. Inside City Limita 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Compton Road 20602 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George Robert Hyde Sarah Elizabeth Canter 19a. tnformant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Frances D. Curtis/Daughter 2429 Grantham Court, Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete

20s. Method of Displ 1 M Buria 2 D Cremation

Washington National Cem. 01-14-2000 Suitland, Maryland

Ġ. **BROHAWN** M00053 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22 Name and Address of Facility
The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604 Approximate Interval Between Onset and Death

tmmediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

HEART ONGESTIVE

1 Yes 2 No 3 Probably 4 Unknown

RENAL FAILURE

24a. Was an eutopsy performed?

24b. Were autopsy findings aveileble prior to completion of cause of deeth?

1 Yea 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural 2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and menner as atated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D-26064

29d. Date signed (Month, Dey, Year) 1-11-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anmangandla Vidyasagar, MD Rt 5&Golden Beach Rd POBox 282 Charlotte Hall, MD 20622

State Registrar

31. Date filed (Month, DAK) 3 2000 32. Register a Signature

filed within 72 hours after death 1 Hygiene. Wher then "netural", or frems 23e

. Pages 1 and 2 should be fill ment of Health and Mental Hant: If Itam 27 Is marked off lury or other traumatic aver

parmit. Page Department of Important: If any injury or once.

Physician

/Medical Examiner

mew

Examiner

Physician/Medical

Completed by

8

Certification: To

edical

certificate

or A

hours 24 hours Funeral

To the P within 2 To the P

Baltimore, Maryland 21215-0020

Demma

Funeral

à

Completed

8

JAN 1 3 2003 Some & species

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month CHARLES EVANS JANUARY 5, 2000 6:30 A.M. 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING & REHAB. AB. CTR. 7. Age (In yrs. last birthday) WORCESTER BERLIN If Under 24 Hrs 6. Sex 1 M 2 □ F If Under 9. Birthplace (State or Foreign Country) W . V A . 5. Social Security Number Date of Birth (Month, Day, Year) Hours Days Months 233-20-4385 Usual Residence of Dece 10a Stata 10c. City, Town or Location 10b. County t0d. Inside City Limits MD. OCEAN CITY 1 Yas 2 □ No WORCESTER 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 135TH STREET 21842 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yas 2 ☐ No Specify: Specify: 3. Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) SECURITY PROTECTION 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) WILBUR EVANS MINNIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA FLAIG 135тн ST., OCEAN CITY, MD., 21842 DAUGHTER 20a. Mathod of Disposition 20b. Piace of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, State 1 Burlai 2 ☐ Cremation 3 Bemoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) BLUE RIDGE MEM. GDNS 1/9 PROSPERITY, 21. Signature of Fundral Service License 22. Name and Addrass of Facility HOME BERLIN, 21811 ULLRICH FUNERAL MD. 23a. Parf1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yas 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only ona) 1 Yes 2 No Hospital: Other: Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

The law requires that the death certificate be executed the burial-tran Box 68760. for use P.O. Division of Vital Records. or Attending Physician: this After 24 hours after death. Funeral Director: A

à Completed

> 29a. Certifier (Check only one)

29b. Signature and title of certifier

Physician/Medicai Examiner edical Certification: To Be

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be

Funeral

Director

28s-f

23a

Pages 1 and 2 should be Illed within 72 hours after end of Health and Mendal Physions.
Int if Illem 27 is merked other than "naturel", or lite ury or other traumetic swent, the Medical Examples.

Department of Important: If

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FEDERICO ARTHES 31. Date filed (Month, Day, Year)

072000

46 TEAL CIRCLE, BERLIN, MD. 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D02026

21811

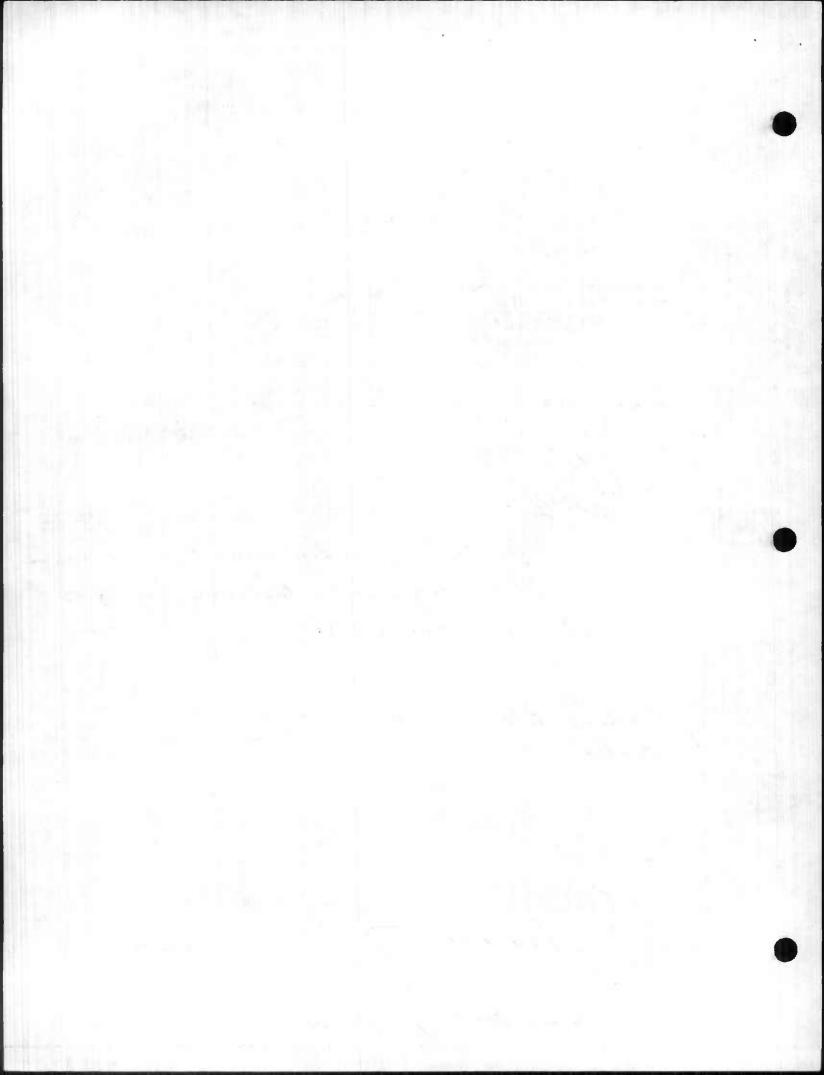
29d. Date signed (Month, Day, Year)

410-641-4400

DHMH 16 Rev 6/95

Hospital

within 2 To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Health and Mans AMEND ITEMS: #23 PART I, 27 PER Certificate of Death 1. Decedent's Name (First, Middle, Last)								Reg. No. 2. Dete of Death 3. Tima of Death			
William Alan	Evans					_	onth Anuary	Dey 04, 2	Year 2000	3:00 PM		
4a Facility Name (If not Institution, give	street and number)			4	lb. City, Town, o			4c. County		0.00 2		
3519 Chur	rch Road				Bowie				ce Geo			
220 02 7001	7. Age (In yrs	s. last birthday, 9 Yrs.	If Under Months		If Under 24 Hi Hours Mi	1. (Me	te of Birth onth, Day, Y			ce (Stete or Foreign y) rly MD		
Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or L	ocation	-	-				100	d. Inside City Limits		
Maryland Prince G	George's	Bowie								Yes 2□No		
10e. Street and Number			10f. Zip	Code				g. Citizen of V				
3519 Church Road				0721				United				
11. Meritel Status 1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2★ No If Yes, Give X Yeer or Detes:	n U,S. 13. Wes Decedent of Hispenic Origin? (Spill Yes, specify Cuban, Mexican, Puerlo 1□ Yes 2℃No Specify:					Bleck, White, etc. Specify: White					
15. Decedent's Edu (Specify only highest gred	ucation	16a. Dece	dent's Usua	el Occup	ation	nrkina	16	6b. Kind of Bu	usiness/Indu	ustry		
Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) Office Clerk					U.S. Government					
17. Fether's Neme (First, Middle, Last)		UIII	ice Cl	erk	18. Mother's N	eme /First				ment		
George A. Evans			18. Mother's Neme (Kathleen					zo gomen	-			
t9a. Informant's Neme/Reletionship (T)	ype, Print)	19b. Meil	Ing Address	S (Street	and Number or	Rural Route	e Number, (City or Town,	State, Zip (Code)		
George A. Evans	Father				Orive Ed							
20a. Method of Disposition ▼OxBurial 2 □ Cremetion 3 □ I						8 Dete	8 Dete2000 20c. Location - City or Town, Stete					
4 □ Donation 5 □ Other (Specify,	Fort Lincoln Gemetery					Brentwood M			laryland			
21. Signeture of Funerel Servica Licen					ss of Facility Evans Fi	ınera	1 Home	e, Inc				
23e. Pert1. Enter the disease, or comp shock, or heert feilure. List only o	lications that caused the de	1 Do not en	6000	Anna	polis Re	Bo	wie M	arylan	d 207	15 Approximate		
Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of): C. Due to (or es a consequence of): Due to (or es a consequence of):												
	d								1			
_	ntributing to death but not re	sulting in the u	undodvina a	ause aiv	en in Pert I.	2	3b. Did tob	ecco uee co	ntribute to	the cause of death		
Pert II. Other aignificant conditions co			indenying c	and gri				O DAIL	3 Prob	ably 4 D Unknow		
Pert II. Other aignificant conditions co			moenyng c			111	1 🗆 Yee	2 LI NO				
Pert II. Other algnificant conditione co			andenying c			24	1 Ved	eutopsy	avai	re eutopsy findings ilable prior to spletion of cause eath?		
Pert II. Other algnificant conditions co			indeliying c			24	te. Wes an	eutopsy ed?	avai com of d	lable prior to		
25. Wes case referred to medical			indenying c		26. Place of D		te. Wes an performe	eutopsy ed?	avai com of d	ilable prior to apletion of cause eath?		
25. Wes case referred to medical exeminer? XXXYes 2 No 27. Menner of Death 1 Neturel 5 Pending	Hospital:	EP/Outpetle 28b. Time of Injury	nt 3 DO	DA Oth	er: 4 Nursing	eeth (Che	1/2 Yes	eutopsy ed?	avai com of d	ilable prior to pletion of cause eath?		
25. Wes case referred to medical exeminer? XXXYes 2□ No 27. Menner of Death	Hospitel: 1 ☐ Inpatient 20	28b. Time of Injury	ont 3 DC	DA Oth 28c Injur Wor	er: 4 Nursing y et k?	eeth (Che	1/2 Yes	eutopsy ed? 2 No No No 6 Oth v injury occur	avai corr of d	ilable prior to pletion of cause eath?		
25. Wes case referred to medical exeminer? XXXYes 2 No 27. Menner of Death 1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. Certifier 1 Certifying Phy	Hospitel: 1 inpatient 2[28a. Dete of Injury (Month, Dey Year) 28e. Pleca of Injury - At building, etc. (Specialistics)	28b. Time of Injury home, ferm, st	ont 3 DO	DA Oth Wor 1 U	ver: 4 Nursing y et k? Yes 2 No	eeth (Chee	1 Yes an performed 1 Yes ck only one escribe however the performed to the cause of	eutopsy ed? 2 No No Ca 6 Other vinjury occur Stete)	avaia com of d 1/2 ner (Specify, rred ber or Rural	ilable prior to injection of cause eath? Yes 2 No Route Number,		
25. Wes case referred to medical exeminer? XXXYes 2 No 27. Menner of Death 1 Neturel	Hospitel: 1 Inpatient 2[28a. Dete of Injury (Month, Day Year) 28e. Pleca of Injury - At building, etc. (Specialistics)	28b. Time of Injury home, ferm, st	ont 3 DO	OA Oth 28c. Injur Wor 1 y, offica et the tir , in my o	ver: 4 Nursing y et k? Yes 2 No	eeth (Chee	1. Yes ck only one scribe how cation (Streety or Town, e to the cau he time, det	eutopsy ed? 2 No No Ca 6 Other vinjury occur Stete)	avaicom of did 120 ner (Specify, rred ber or Rural anner as sta and due to	ilable prior to injection of cause eath? Yes 2 No Route Number,		
25. Wes case referred to medical exeminer? XXXYes 2 No 27. Menner of Death 1	Hospitel: 1 inpatient 2[28a. Dete of Injury (Month, Dey Year) 28e. Pleca of Injury - At building, etc. (Specialistics)	28b. Time of Injury home, ferm, st	ont 3 Do	OA Oth 28c. Injur Wor 1 y, offica et the tir , in my o	er: 4 Nursing y et k? Yes 2 No ne, dete end ple pinion, deeth oc	eeth (Chee	4e. Wes an performed a perform	eutopsy ed? 2 No No No Ca 6 Other injury occur Stete) Use(s) and make e end placa,	ner (Specify, rred	Route Number, Route Number, aled. the ceuse(s)		
25. Wes case referred to medical exeminer? XMXYes 2 No 27. Menner of Death 1	Hospitel: 1 inpatient 2[28a. Dete of Injury (Month, Dey Year) 28e. Pleca of Injury - At building, etc. (Special of examination of examinati	28b. Time of Injury home, ferm, st inity) howedge, deet etion and/or le	ont 3 Do	OA Oth 28c. Injur Wor 1 y, offica et the tir , in my o c. Licens . C . M	er: 4 Nursing y et k? Yes 2 No ne, dete end ple pinion, deeth oc	eeth (Check Home 38 28d. D	4e. Wes an performed a perform	eutopsy ed? 2 No Note a 6 Other injury occur set end Numb Stete) Use(s) and make end placa, d. Date signe	avaicom of did 120 anner (Specify, rred anner as sta and due to did (Month, E	Route Number, Route Number, aled. the ceuse(s) Day, Year)		

Registrar **DHMH 16 Rev 6/95**

Miles To Salar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Defe of Death 3. Tima of Death 1 Decedent's Name (First Middle Last) Dev **Physician** Esposito Trene Ernestene 2000 12:57PM January /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, give street end number) **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2√2 F Months Hours Min Yrs. Director 579-30-4315 March 6, 1925 West Virginia Usuei Residence of Decedant permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any highry or other traumatic svent, the Medical Exacting must be northest and once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Prince George's Upper Marlboro 10e. Streef end Number 10g. Citizen of Whet Country? 9809 Lemocks Drive 20772 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yas, Give Year or Detes: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8th N/AWaitress Food Industry 16. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Mclane Rosalee North Mayes 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Michael D. Davis (Son) 9809 Lemocks Drive Upper Marlboro, Maryland 20772 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 5,2000 Jan. 1 Buriel 2 Cram 3 DRemoval from State P Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Nama and Address of Fecility Lee Funeral Home, Inc. ral Service Lic 6633 Old Alexandria Ferry Road Clinton, MD20735 M01095 of the line control of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Cardiopulmonary Arrest: Aspiration Pneumonia Examiner Due to (or es e consequenca of) Examiner Hypertension: Stroke physician end s the burial-trensit death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 88 USB P.O. 23b. Did tobacco use contributs to the cause of death? ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were eutopsy findings evalleble prior to 24e. Wes an eutopsy performed? Completed completion of cause of deeth? page 2 certificate has 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 2 this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, sfreet, fectory, office building, etc. (Specify) 2 Direc 4 Homicide 6 filled in Hospital 24 hours XX Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, and dua to the causa(s) and menner es steted. 29e, Certifian edical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one)

31. Dete filed (Month, Day, Year)

JAN 0 7 2000 State Registrar

29b. Signature and this of certifier

M. Saeed Koolaee M.D.

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

5632 Annapolis Road #4 Bladensburg, MD 20710 32. Registrer's Signature

29c. Licansa number

46260

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Committee to the second second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Patricia Freyman January 2000 11:52am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 9400 Chesapeake St LaPlata Charles Birthplace (State or Foreign Country) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 213-38-9414 1□M 20 F Sept 7 1939 Director Delaware Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. Stete 28a-f show must be notified at Md Carroll X□ Yes 2□ No Finksburg Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 2436 Bollinger Mill Road 21048 USA Herrie 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Stelus 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) registered nurse health care 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental in Important: If Item 27 is marked and thy Inlien. Be William Stansbury Helen Louise Bankard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Clarence Dale Freyman (spouse) 2436 Bollinger Mill Rd., Finksburg, Md 21048 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State
4 ☐ Donetion 5 ☐ Other (Specify) All County Cremation Sykesville, Md. 1-5-00 21. Signature of Funerel Service Licensee 22, Name end Address of Fecility Haight Funeral Home & Chapel Paige Hight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediete Causa (Finel Ischemic Heart Diease disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 the death certificate be Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 DiOther (Specify) Motest 1 Nes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) SUT 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a Certifies 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-50883 1-03-00 30. Name and address of person who completed cause of death (Nerm 23m) (Type, Print) St. Mary Hospital, Dept. of Pathology Yahia M. Tagouri, MD 25500 Pt. Lookout Rd., Leonardtown, Maryland 20650 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 0 4 2000 Registrar

of the same

1111		Certificate of Death	nd Mental Hygie	g. No.	01468
		1. Decedent's Nama (First, Middla, Last)	2. Data of Death		3. Tima of Deat
Physic		Ruthetta Romaine Fints	Month (2)	Dey	Yaar 11:45
/Medi Exami			, or Location of Death	4c. County of	Deeth
		COCH Carroll County General Hospital West	musta	Carro	1/
Funeral	Г	5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) if Under 1 Year If Under 24 Months Days Hours		(and	9. Birthplaca (Stata or Fore
Director		215 24 1781 15W 251 72 Yrs.	Min. (Month, Day, Y	/27	Country) MD.
pu *	7	Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location	,		
be filed within 72 hours after death with the Maryland tal Pyglene. I other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, its Medical Examiner must be notified at	5				10d. Inside City Lin
28a-1	Director	MD. Carroll Westminster 10e. Street and Number 10f. Zio Coda	1.10		
with with	ត់		100	g. Citizan of Wh	nat Country?
a 23a	Funeral	431 E. Main Street 2/157	0.10	U. 5.	. A.
items items	Š	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 1 Navar Married 2 Armed Forcas? 1 Yas 2 Maried 1 Yas, specify Cuban, Maxican, P	or No- Puarto Rican, atc.)		- Amarican Indian, Whita, atc.
TS af	by F			Specify:	111.1
n 72 hours natural',		15. Decedant's Education 16a. Dacedant's Usual Occupetion	16	6b. Kind of Busi	While
n C	Completed	(Specify only highast grada complated) (Giva kind of work dona during most of	f working	JO. KING OF DUSI	nasamodatiy
d z should be filed within the end Mental Hygiene. 7 Is marked other than traumatic event, the M	EO	Elemantary/Secondery (0-12) Collega (1-4or 5+) Supervisor-housekee	nina W	ectminst	ter Nursing He
ent of the	BeC		Nama (First, Middle, Ma		
fenta de	To B	Harvey Myers	Ada G	casev	,
2 should end Mer Is marks aumatic		19a. Informant's Name/Relation hip (Type, Print) 19b. Meiling Addrass (Streat and Number of			tata, Zip Coda)
1 and 2 s Heelth er em 27 ls ther trau		Kenneth R. Fritz husband 431 E. Main Street	Westmins	ter M	D 21157
ges 1 and t of Heelth If item 27 or other to		20a. Mathed of Disposition 20b. Placa of Disposition (Name of			ity or Town, Stata
reges net of nt: If it		Durial 2 Ucramation 3 Linamoval from Stata	15 20001		0.17
글 된 된 등		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	P. + 5.000 L	I Hama	, MD.
Depentiment say in porce.		10 V Q Q 4/2)	Washington Ro	and me	chaper, r.m.
		Was			
/Medical		23a. Part Entar tha disaasa, or complications that causad he daath. Do not anter tha mode of dying, such as car shock, or heart tailure. List only one cause on each line. Immediate Causa (Final disaase or condition	tminster MI	2.116	Approximete Intarval Between
/Medical Examiner	Aedicai Examiner	Property were and the second s	tminster MI	2.116	Approximete Intarval Between
/Medical Examiner	ŭ	Immediate Causa (Final disaase or condition rasulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaasa or injury that initiated evants Due to (or as a consequence of):	Training ter, MI reliec or raspiratory arras	P. 2//6	Approximate Intarval Between Onset and Death Onset and Death
/Medical Examiner	Physician/Medical Ex	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or influry that initiated evants rasulting in death) Lest a. Chron - Obs Journe Pullin. Dua to (or es e consequence of): Dua to (or as a consequence of): C. Dua to (or as a consequence of): d.	Training ter, MI reliec or raspiratory arras	P. 2//6	Approximate Interval Between Onset and Dealt
/Medical Examiner	by Physician/Medical Ex	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or influry that initiated evants rasulting in death) Lest a. Chron - Obs Journe Pullin. Dua to (or es e consequence of): Dua to (or as a consequence of): C. Dua to (or as a consequence of): d.	Training ter, MI reliec or raspiratory arras	acco use contr	Approximate Intarval Between Onset and Death Death Onset and D
/Medical Examiner	by Physician/Medical Ex	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or influry that initiated evants rasulting in death) Lest a. Chron - Obs Journe Pullin. Dua to (or es e consequence of): Dua to (or as a consequence of): C. Dua to (or as a consequence of): d.	23b. Did tobe 1 Yes 24a. Was an aperforme	acco use contris 2 No 3	Approximete Intarval Between Onset and Death O
/Medical Examiner	Completed by Physician/Medical Ex	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of):	23b. Did tobe 24a. Was an performe	acco use contribution of the contribution of t	Approximate Intarval Between Onset and Death Death Onset and D
/Medical Examiner	Be Completed by Physician/Medical Ex	Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): Dua to (or as a consequence of): C. Dua to (or as a consequence of): Dua to (or as a consequence of): d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?	23b. Did tobe 24a. Was an eperforme 1 \(\text{Yes} \) Death (Check only ons)	acco use contribution of the contribution of t	Approximate Interval Between Onset and Death Death Onset and D
/Medical Examiner	To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaase or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): C. Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): d. Dua to (or as a consequence of): 1. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 25. Was case referred to medical axaminer? 1. Yes 2. Hospital: 1.	23b. Did toba 1 Yes 24a. Was an experiors 1 Yas Death (Check only ona) ng Homa 5 Rasidence	acco use contribution of the contribution of t	Approximate Intarval Between Onset and Death Death Onset and D
ing ringstrain. The law requires that begins the beam continued by the ettending physician and meral director, page 2 should be detached for use as the buriel-transit	To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in daath) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaase or injury that initiated evants rasulting in daath) Lest Dua to (or as a consequence of):	23b. Did tobe 1 Yes 24a. Was an eperforme 1 Yas Death (Check only ona) ng Homa 5 Rasidence 28d. Dascribe how	acco use contribution of the contribution of t	Approximate Intarval Between Onset and Death Death Onset and D
Machine Trystoler. The law includes the time death continued to execute the specification and the funeral director, page 2 should be detached for use as the buriel-transit as a second to the funeral director.	To Be Completed by Physician/Medical Ex	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undarklying Causa (Disease or injury that initiated evants resulting in death) Lest Dua to (or as a consequence of):	23b. Did toba 1 Yes 24a. Was an aperforme 1 Yas Death (Check only ona) ng Homa 5 Rasidence 28d. Dascribe how	acco use control 2 No 3 autopsy 3 autopsy 3 ca 6 Othar injury occurred	Approximate Intarval Between Onset and Death Death Onset and D
About a first of attentions of a specification of a	Certification: To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in daath) Dua to (or es e consequance of): Dua to (or as a consequance of): Dua to (o	23b. Did toba 1 Yes 24a. Was an aperforme 1 Yas Death (Check only ona) 1 Bascribe how 28f. Location (Stree City or Town, 3)	acco use contribution in the control of the control	Approximete Intarval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Death Onset and Death
About a first of attentions of a specification of a	edical Certification: To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disaase or injury that inhited evants rasulting in daath) Lest Dua to (or as a consequence of): C. Dua to (or as a consequence of): Dua to (or as a conseq	23b. Did tobe 1 Yes 24a. Was an experiors 24a. Was an experiors 28d. Death (Check only one) 28d. Describe how 28f. Location (Streen City or Town) 28d. Death due to the cause occurred et the time, date	acco use contribution of the contribution of t	Approximate Intarval Between Onset and Death Onset
The function of Attentions Financial in the law requires that the bear certificate be executed this A hours effer death. The Funcial Director: After this certificate has been signed by the ettending physician end in plately filled in by the funeral director, page 2 should be detached for use as the buriel-transit in the funeral director.	Certification: To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disaase or injury that inhited evants rasulting in death) Lest Dua to (or as a consequence of): C. Dua to (or as a consequence of): Dua to (or as a conseq	23b. Did tobe 1 Yes 24a. Was an eperforme 1 Yas Death (Check only ona) 28d. Dascribe how 28f. Location (Stre-City or Town.) 28d. Dascribe town, date on the cause occurred et tha tima, date	acco use contribution of the contribution of t	Approximete Intarval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Death Onset and Death
Nospital or Attending Physician: The law requires that the death certificate be executed to the Athorise fact death. As hours effect death. Function: After this certificate has been signed by the ettending physician end left filled in by the funeral director, page 2 should be detached for use as the bunel-transit of the funeral director.	edical Certification: To Be Completed by Physician/Medical Ex	Immediate Causa (Final disaase or condition rasulting in daath) Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disaase or injury that inhited evants rasulting in daath) Lest Dua to (or as a consequence of): C. Dua to (or as a consequence of): Dua to (or as a conseq	23b. Did tobe 1 Yes 24a. Was an performe 1 Yas Death (Check only ona) ng Homa 5 Rasidence 28d. Dascribe how 28f. Location (Stre- City or Town, solaca, and dua to the cause cocurred et the time, date 410 410 410 410 410 410 410 41	acco use contribution of the contribution of t	Approximate Intarval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Onset and Death Dea

South gran to their beat the specific on evening and Stanfor (E. Miller Tors of population being a like the profile of the formation of the first of the fi All angular series and terror of the property of the property

Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Victor Nelson Ferreira, Sr. January 3, 2000 1:40 pm 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months 1 ₺ M 2 D F Yrs. May 14, 66 1933 Uruguay, S.A. 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No Silver Spring 10f. Zip Code 10g. Citizen of What Country? 20904 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck White etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 N Yes 2 No Specify: Uruguay Specify: Hispanic Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Postal Employee Federal Government

577-74-8967 Director Usual Rasidence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental thygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Examine must be notified at once. Director Maryland Montgomery 10e. Street and Number 14000 Castle Boulevard #202 Funerai 1 ☐ Never Merried 2 X Married Baitimore, Maryland 21215-0020 À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 17. Falher's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Octacilio Ferreira Dacila Pereira 19b. Meiling Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Maria M. Ferreira - Wife 14000 Castle Boulevard #202, Silver Spring, MD 20904 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other plece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Metropolitan Crematory 01/04/00 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility
Gasch's Funeral Home, P.A. 21. Signeture of Funerel Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Ceuse (Finet disease or condition resulting in deeth) /Medical Examiner

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician is be detached for use as the buria Physician/Medical

Physician

/Medical

Examiner

Funeral

Due to (or as a consequence of):

- Separations	ontributing to death but not re	suiting in the underlying cau	se given in Pert I.	1 Yes 2 No	3 Probably 4 Unknow
- Diubete.		ل ي		24a. Wes an eutopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?
			26 Place of De	eth (Check only one)	10.162 20.10
25. Was case referred to medical exeminer? 1 Yes 28 No	Hospitel: Inpatient 2	☐ ER/Outpatient 3☐ DOA	Othor		ner (Specify)
27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not b 4 Homicide determined		home, ferm, street, fectory, c	ffice	28f. Location (Street and Numb City or Town, Stete)	ber or Rural Route Number,
29a. Certifier 1 ☐ Certifying Ph				e, and due to the cause(s) and murred et the time, date end place,	
20h Siznature and titis of conting		29c	icense number	29d Date sinns	d (Month Day Year)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture and title of cert 29c. License number R Rushid university

29d. Date signed (Month, Day, Yepr)

Approximete Interval Between Onset and Death

30. Name and address of parsop. o completed cause of death (Item 23a) (Type, Print)

32. Registrar'a Signature 31. Date filed (Month, Day, Year)

Registrar

JAN 0 6 2000

DHMH 16 Rev 6/95

The law requires that the death certificate be executed

or Attending Physician:

funeral

After

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2000 1:45 P.M Year Month Doris E . Fields 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Burnie Arundel Hospital Anne Arundel | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) | Sept 12,193 | 1 Columbus, Ohio If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 1 M 2 Str Days Months 288-28-1395 68 Vrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Arundel Millersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8217 Rupert Rd 21108 U.S.A 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yea 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Merried 1 ☐ Yes 2X No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Beauty Consultant 12 Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Oliver Banks Eunice Bailey 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William L. Fields-Husband 8217 Rupert Rd Millersville MD 21108 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a Method of Disposition Date 1 Burial 2 □ Cremetion 3 □ Removel from Stete Maryland Veterans Cem 1-11-00 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) e end Address of Facility J.B. Jenkins 7474 Landover Road 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) myocarolac Due to (or as a consequence of): EMEMA MONASM Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FAILURE CAROMC CENAL Due to (or es e consequence of): BIRESTE CHROMC ORSTRUCTURE Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute/to the cause of death? DIABETES 3 Probably 4 Unknown 1 Yes 2 No ME LLITUR 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 □ Yea 2 □ No 1 ☐ Yes 25. Was casa relerred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be axecuted P.O. Box 68760, Records, Division of Vital After this

Physician/Medical Examiner attending physician and for use as the burlal-trans signed be del by Be Completed Certification: To

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Meniel Hygiene. Important: If Itam 27 is marked other than "natural", or fleme 23a way injury or other traumatic avant, the Medical Examinat mass 1866.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Doris

Fields,

Director

Funeral

à

Completed

Be

2

or Attanding Physician: Hospital or Attanding
 24 hours after death.
 Funeral Diractor: After filled in by completely To the To To the F

Medical

State Registrar

morning MOKIN 31. Dale filed (Month, Dey, Year) JAN 0 7 2000

29e. Certifier

(Check only one)

29b. Signeture and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hozpital 32. Registrar's Signature

MI

Dowe Glen Burno

🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Dev. Year)

Guyany

2000

1 2008 C Secretary 2008

Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

HELEN G.	FITZPATRICK	2. Date of De Month	eath Day	Year	ime of Death					
4a Facility Neme (If not institution, give	b. City, Town, or	Januar Location of Deat	4		:25 A.M					
5 Social Security Number 6 Se	Road Apt. # 2	and the second s	nder 1 Year ths Deys	Hyatt # Under 24 Hr Hours Min	sville Prince George's 8. Dete of Birth SEPI, 20, 1927 WEST VIRG					
Usual Residence of Decedent	500 Sec. 100	2000			peri.	1521	***************************************			
MARYLAND PRINCE	The second secon	ty, Town or Location HYATTSV I	ILLE				1000000	ide City Limits ¥Yes 2□No		
10e. Street and Number			Zip Code			10g. Citizen of V	What Country?			
7911 RIGGS R	ACTION TO THE STREET			0783			STATES			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4XXX orced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes X XIX No If Yes, GNO Year or Dates:		specify Cubs	Specify:	Specify Yes of N to Rican, etc.)		14. Race - American Indian, Black, White, etc. SpecifiAFRO - AMERICAN			
15. Decedent's Ed (Specify only highest grad	upation de completed)	16a. Decedent's L (Give kind of	Jaual Occup work done	ation during most of we	orking	16b. Kind of Bi	usiness/Industry			
Elementary/Secondary (0-12) N/A	College (1-4or 5+)		EKEEPE			PRIVA	TE			
17. Father's Name (First, Middle, Last) N/A					G . L	, Maiden Suman EE	ne)			
19a. Informant's Name/Relationship (7 HOWARD FITZPAT)						oer, City or Town, YATTSVIL				
1 Denation 3 Department of Spacify 21. Signature of Furiery Service Licent 23a. Part 1. Enter the disease, or comp	EDWARD M.	DUDE EY	3200	ss of Facility EY FUNER RHODE I	AL HOME SLAND A	2000 CL /E., MT.	RAINIE			
disease or condition resulting in death) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								C 150 VI		
Cause (Disease or injury that initiated events	с.									
cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	c. Due to (c	r as a consequence	of):							
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	r as a consequence	of):	on in Part I.		Tobacco use co I Yes 2□ No				
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	r as a consequence	of):	en in Part I.	1C	and the same state of	3 Probably 24b. Were au	4 Unknow		
Cause (Disease or injury that initiated events	c. Due to (c	r as a consequence	of):	on in Part I.	1C 24a. Wa peri	Yes 2□No	3 Probably 24b. Were au available complete	4 ☐ Unknow topsy findings prior to on of cause		
Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions co	d. Due to (c	or as a consequence	of): ng cause giv	26. Place of Do	24a. Wa perl	Yes 2 No	3 Probably 24b. Were au available complete of death	4 Unknown topsy findings prior to on of cause		
Cause (Disease or injury that intieted events resulting in death) Lest Part II. Other significant conditions co	d. Due to (c d	or as a consequence	of): ng cause giv	26. Place of Doer: 4□ Nursing	24a. Wa per XX nath (Check only Home XX) Res	Yes 2 No	3 Probably 24b. Were au available complete of death (X Yes	4 Unknow topey findings prior to on of cause		
Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions co	d. Due to (c. d. Due to (c. d. Due to (c. d. Due to (c. d.	ER/Outpatient 3D Injury M.	of): ng cause giv 1 DOA Oth 28c. Injur Wor	26. Place of Dier: 4 Nursing y at k7	24a. Wa per 100 March (Check only Home 50 Rescribe 28f. Location.	Yes 2 No	3 Probably 24b. Were au available complets of death 12 Yes ner (Specify)	4 ☐ Unknown toppy findings prior to on of cause ? 2 ☐ No		
Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions	c. Due to (c. d	ER/Outpatient 3D Injury M. ome, farm, street, factors of the street of t	of): ng cause giv 3 DOA Oth 28c. Injur Wor 1 Ctory, office	26. Place of Doer: 4□ Nursing yat k? Yes 2□ No	24a. Wa peri XX hath (Check only Home SXI Res 28d. Describe 28d. Location City or 7d.	Yes 2 No s an autopsy owned? Yes 2 No one) idence 6 Dote how injury occur (Sineet and Numbers, State)	3 Probably 24b. Were au available complete of death (X Yes wer (Specify) med ber or Rural Routenamer as stated.	4 ☐ Unknown topey findings prior to on of cause ? 2 ☐ No		
Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions colored examiner? 1 Yes 2 Np 27 Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	Due to (c d. Nospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - Al houlding, etc. (Specian: To the best of my kny liner: On the basis of examina and manner stated.	ER/Outpatient 3D Injury M ome, farm, street, factor and/or investigation and/or investigation.	of): ng cause giv 3 DOA Oth 28c. Injur Wor 1 Ctory, office	26. Place of Dier: 4□ Nursing yat k? Yes 2□ No	24a. Wa peri XX hath (Check only Home SXI Res 28d. Describe 28d. Location City or 7d.	Yes 2 No s an autopsy omned? Yes 2 No one) idence 6 No how injury occur (Street and Numbers, State) cause(s) and mandate and place.	3 Probably 24b. Were au available complete of death (X Yes wer (Specify) med ber or Rural Routenamer as stated.	4 Unknown toppy findings prior to on of cause 2 □ No te Number,		
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions colored examinar? 25. Was case referred to medical examinar? 1	Due to (c	ER/Outpatient 3D Injury M ome, farm, street, factor and/or investiga	DOA Oth 28c. Injur tory, office red at the tirtion, in my o	26. Place of Dier: 4□ Nursing yat k? Yes 2□ No	24a. Wa peri XX hath (Check only Home SXI Res 28d. Describe 28d. Location City or 7d.	Yes 2 No s an autopsy omed? Yes 2 No one) idence 6 Oth how injury occur (Street and Number, State) cause(s) and m., date and place, 29d. Date signe	24b. Were au wallable complets of death's Yes her (Specify) med.	4 Unknown toppy findings prior to on of cause ? 2 No te Number, ause(s)		

which is the state of the last

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) JANUARS 05,2000 MAVIN DEAN GRIFFIN 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) PRINCE GEORGES 59th CHEVERLY 2410 AVENUE If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Months Days Hours Min MARYLAND 1 M 200 Yrs. 83 NOV. 4,1916 214-03-4655 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND PRINCE GEORGE'S CHEVERLY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2410 59TH AVENUE 20785 U. S. A. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, While, etc. Yes ANO 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 TNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MOTOR VEHICLE ADMIN. CLERK 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) ELSIE THOMAS LUTHER DEAN 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 246 HARBOR DRIVE DRUM POINT, MARYLAND 20657 LUTHER DEAN / BROTHER 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition THAT. Burial 2 Cremetion 3 Removal from State 10,2000 SUITLAND, MARYLAND CEDAR HILL CEMETERY 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND ease, or complications that caused the death. Do not enter the mode ot dying, such es cardiec or respiratory errest re. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final . ARTERIOSCUEROTIC CARPLOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural

Physician /Medical Examine that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f ahow

ma 23a or 2

*natural", or items ?

Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.
Int: if item 27 is marked other than "natural", or item inty or other traumatic avent, ins Medical Experimentry or other traumatic avent, ins Medical Experimentry.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

The law

Directo

Funeral

by

Completed

death with the Maryland

physician and the burial-transit signed by ti d be detech certificate has blinector, page 2 s Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica

Examiner funeral in 24 hour.

Physician/Medical þ Completed Be Certification: To

examiner 1 27. Manner of Deeth

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Localion (Street and Number or Rural Route Number, City or Town, State)

29b. Signature app

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Nama arti

(Item 23a) (Type, Print) Deve CHEVERLY, MARRAND 20785

JANUARY 07, 2000

Registrar

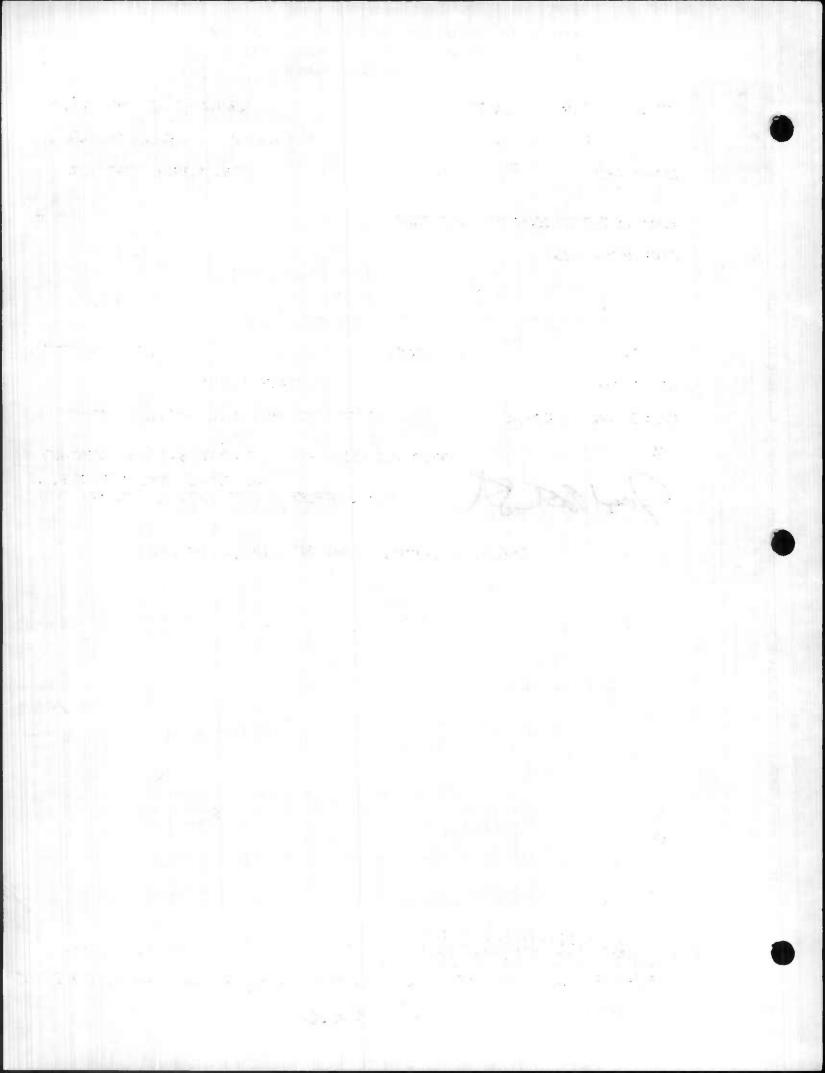
Medical

MARIO F GOLLE 31. Dete filed (Month, Dey, Yeer)

JAN 1 0 2000

300 1 32. Registrar's Signature

To the Hosp within 24 hos To the Fune completely fi



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01473 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 2150 Ruby S. Gardner 5, January 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth Min. 1900 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M XXE 99 Yrs. 219-44-6970 Director Kentucky **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 ☐ Yes 2 No Director MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 902 W. Baker Street 21009 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: λq Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Hygiene. College (1-4or 5+) Homemaker In home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If Itam 27 is marked out Be Thomas S. Sayler Cora Preston 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George H. Gardner III (Son) 1531 Perryman Road, Aberdeen, Maryland or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/8/00 Abingdon, Maryland 21. Signature of Fundral Service Licenses 22 Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Gan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final useun disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Due to (or as a consequence of): detached for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 20 No 3 Probably 4 Unknown Records, ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Baus certificata 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Affer Division or Attending 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 29a. Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner stated. within 2 ŝ 29c. License number 29b. Signature and title of certifier 29d. Dafe signed (Month, Day, Year) 515 Suan

State Registrar

anyanu5,3000

Union

Avenue

Houre de Grace mo 21078

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

ULO

31. Date filed (Month, Day, Year)

801

32. Registra's Signeture

JULY T WAY.

Physician

/Medical

Examiner

Hospital or Attanding Physician: The law requires that the death certificate be associted Ashours after death.

Funeral Director: After this certificate has been signed by the attending physician and remain Director; After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Be Completed by

Medical Certification: To

00-0166-003 crn Frederick Goo AMEND ITE	odman MS: #23 1							. Assure All Health and M Death	-	_	ible.	1474	
Physician /Medical	Decedent's Nama (First, Middla, Last) FREDRICK FENNELL GOODMAN								2. Data of Dea Month Januar	Day Yaar			
Examiner	4a Facility Neme North	· compared to the	give street and no Hospita					4b. City, Town, or Lo Glen Bur			ty of Death Arun	del	
Funeral Director	5. Social Security Number 6. Sex 147-64-3019		7. Aga (In yrs 36	yrs. last birthday) If Under 1 Months I		Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day FEB 3	9. Bir 1963 S		rthplaca (Stata or Foreign ountry) • C •		
Maryland 4 show	Usual Rasidence 10a. State MD					ocation N			10d. In				
after death with the Maryland or items 23e or 28e-f show union must be notified at / Funeral Director	10e. Street and N				10f. Zip	Coda	10g. Citizan of What Country? UNITED STATES						
5 28 5	11. Merital Status 1 Navar Ma 3 Widowed	cedant Ever in U orcas? 2X No iiva Detas:		13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: 14. Rece - Amarican Indier Black, White, atc. Specify: BLACK					, atc.				
1 21215-002 led within 72 hours within 72 hours within the returning the received by Completed by	(Spe	15. Decedent's Education (Specify only highest grada completed)					Sa. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Ind					ndustry	
2121 d within piene. r then r	Elementary/Sec		MANAGER AUTOMOTIVE						/E				
Marylanc nd 2 should be fit ith and Mental H Z7 is marked out r traumatic aver	17. Fether's Name JOHN A			18. Mother's Name (First, Middla, Maidan Sumama) BARBARA THOMPSON									
	19a. Informant's Name/Relationship (Type, Print) ANGEL GOODMAN / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7906 CANTER CT., SEVERN, MD 21144						p Code)		
mon	20a. Mathod of Disposition 1 X Burial 2 Cramation 3 Ramovel from Stata				Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State								
Baitimo Department of Important if it any injury or ence.	4 Donation 5 Other (Specify) FO 21. Signature of Funeral Service Licenses WHOSE					INCOLN CEMETERY 1-18-00 BRENTWOOD, MD 2. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20747							

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Batween Onset end Death

tmmediata Causa (Final disaase or condition rasulting in daath)

SARCOIDOSIS WITH CARDIAC INVOLVEMENT

Dua to (or as a consequanca of)

Sequentially list conditions, It any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Dua	to	(or	as	a	consequenca	of):

Dua to (or as a consequence of)

Part II. Other eignificant conditions contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

2 No

26. Place of Death (Check only ona)

1 Nas 2□ No

25. Was casa rafarred to medical 1⊠Yes 2□ No 27. Mannar of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 28b. Tima of

28c. Injury at Work?

1 Yas

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian

1 Natural

2 Accidant

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. Licansa number

29b. Signatura and titia of cartifia

O.C.M.E.

29d. Data signad (Month, Day, Year) January 11, 2000

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

completely filled in by

To the Hospital owithin 24 hours a To the Funeral D

31. Dete filed (Month, Day, Year)

5 Pending

invastigation

6 Could not be determined

32. Registrer's Signatura

JAN 1 8 2000

Strate MAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Geral Day Month Year **Physician** May 11:50 AM 2000 DRAULCH /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year | Months | Days 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 XF 577-68-2645 82 Yrs. FEB.14,1917 NORWAY Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location show MD. MONTGOMERY ROCKVILLE 1 XYes 2 No Director 25a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 9701- VEIRS DRIVE 20850 USA "natural", or flams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY NOT AVAILABLE 12 17. Fathar's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I next of Health and Mental ent: If New 27 is marked of SAM AVEN AMANDA BECK 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If New 27 is any injury or other trau JAMES A. GERALY-HUSBAND 6612- RANNOCH RD., BETHESDA, MD. 20817 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremetion 3 Removel from State METROPOLITAN CREMATORY-1/4 ALEXANDRIA, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fyneral Selvice Licensee 22. Name and Address of Facility HYSONG CO., INC. FUNERAL HOME W. W 1300 - N STREET, NW, WASH., DC 23a. Part t. Enter the disease, or shock, or heart failure. List or heart failure. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final Urosepsis 2 days disease or condition rasulting in deeth) Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 1 No 1 Yes 2 No certificate Division of Vitai Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certificately filled in by the funeral director. Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menger of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. othe h. within 2/ To th 29b. Signeture and title of certifier D33849 30. Name and address of pages who completed cause of death (item 23a) (Type, Print) Drive Rockville, MD 20850 dical 70 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 6 2000 Registrar

133. A TONAL BOOK & O WAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Matthew C. Gray Janaury 5, 2000 5:03 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 MM 2□ F Days Hours Yrs. Nov. 18, 214-76-5035 1958 Washington, DC Director Usual Rasidence of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. net of Health and Mental Hygiene, not if them 27 is marked other than "naturel", or items 23s or 28s-f show r 28a-f show a nottiled at 10a State 10h County 10c. City. Town or Location 10d. fnside City Limits 1 X Yes 2 No Maryland Prince George's Directo Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturel", or itema 23a or traumatic event, the Medical Examiner must be a 2901 Tremont Avenue 20785 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Industry Quality Control Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James C. Gray Charlotte M. Donaldson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Tremont Avenue, Cheverly, MD 20785 flem 2. Charlotte M. Gray - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State = ö permit. Page Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/05/00 Alexandria, Virginia 22. Name and Address of Facility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one causa on each line. Approximata Intarvsl Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examine and bransh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last physician and the burland Division of Vital Records, P.O. Box 68760 that the death conflicate be Physician/Medical Ħ ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 22 signed by t d be detach 38 NO 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? H page 2 2 1 Yes 2 No certificate 25. Was casa refarred to medical examiner? 89 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Yes 2/2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Bits 27. Mariner of Daath Data of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? After Attanding Natural 5 Pending investigation 1 Yes 2 Accident 3 Suicida 6 Could not be datermined Location (Straat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) after A 4 Homicida To the Hospital
within 24 hours a
To the Funeral C
completely tilled Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the causa(s) and manner as stated.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month: Day, Year) 29c. License number 29b. Signeture end title of certifier ere 0 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) 11922 Twinlakes Drive #04, Beltsville, MD 20705 Lydia Gilbert-McClain, M.D.

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 6 2000

32. Registrar's Signature B. Spark

MAN OF 2000 PART

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Jahl 3Dey 2000 eer Catherine L. Gorski 10:47PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Hospice House Linthicum Anne Arundel ff Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth
Months | Deys | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Yrs. 578-09-9258 81 Feb. 1,1918 Washington DC Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10d. inside City Limits 10b. County 1 Yas 2 No Maryland Anne Arundel Director Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 371 Southport Drive 21037 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 14. Reca - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No by Specify: 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be John Fred Louise Μ. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Michael (Daughter) 8200 Chancery Court Alexandria VA 22308 20a. Method of Disposition

*Buriel 2 Cremetion 3 Removel from Stete 20b. Pleca of Disposition (Name of cametery, cremetery or other piece) Jan. 8, 2000 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signeture of Funerel Service License 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear feilure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Finel disease or condition resulting in death) LUNG CAN CER Due to (or es e consequence of): Physician/Medical Examiner 6mo. LUNG CANCER to mediasnoun metastatic Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Chronic Obstructure Pulmonery Disease Completed by 24b. Ware autopsy findings evellable prior to completion of cause of deeth? 24e. Wes an autopsy performed? XX 1 DYes 20 NoA Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dether (Specify HOSPICE Certification: To 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 26b. Time of 28c. Injury et Work? 26d. Describe how Injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 26e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 26f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

that the death certificate be executed the burial-transit physician 88 for use been signed by the a should be detached page 2 has certificate or Attending Physician: this

P.O. Box 68760,

Division of Vital Records,

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be not? at an once.

Baltimore, Maryland 21215-0020

funeral director, After death. 24 hours after death Funeral Director: filled in by

Hospital Medical To the within 2 State Registrar

29e. Certifier

(Check only one)

29b. Signeture end title of certifier Aluller 29c. License number 04-02/6.

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

29d. Dete signed (Month, Day, Year) 04 00

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dennis Cullen, M.D. 4333 Old Branch Ave. Marlow Heights, Md.

31. Dete filed (Month, Dey, Year)

JAN 0 7 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer TON **Physician** 6uy AVID 01 4/5 JAN 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSP ... TNNAPOLIS GeN unde If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplaca (State or Foreign Country) Days Months Hours 1XMM 2□ F 42 220 70 5432 4, 1957 Washington D.C Usual Residence of Decedent 10c. City, Town or Location 10d. toside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Edgewater Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 621-M Mayo Road 21037 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Never Married 2 Married ☐ Yes 2☐No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Political Senator Aide 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Luke Tate Guyton Mary Alice Woffard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John . Guyton Brother 621-M Mayo Road Edgewater Maryland 21037 20b. Place of Disposition (Name of cametery, crematory or other place) Jan. 4, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 22 X Cremation 3 ☐ Removal from State The Huntt Crematory Waldorf Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licanses Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only on cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Cerebra MINUtes Due to (or es a consequence of): Examiner Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24s. Was an autopsy 24b. Were eutopsy findings svallable prior to completion of cause of death? Completed 1 Yes 20040 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Monpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: OPIAt 1 Naturat 5 Pending 1 Yes 2 No OOK Investigation 99 UNKM 2 Accident 31 281. Location (Street and Number or Aural Aoute Number, City or Town, State) Edgewater, MD 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Home agewater, mD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one)

24 hours after death. filled in by Hospital completaly To the within 2

Funeral

Director

ahow

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

I Hygiene.

permit. Pages 1 and 2 should be filed v. Department of Health end Mentel Hygie. Important: If item 27 is marked other the any injury or other treumatic event, this page.

Physician

/Medical

Examiner

ettanding physicien and for use as the bunal-transit

signed by

has page 2

certificate

this

funeral

2

USB as t

requires that the death certificate be axecuted

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

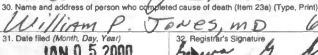
3altimore, Maryland 21215-0020

Registrar

31. Date filed (Month, Day, Year) JAN 0 5 2000

illiam

29b. Signature and titte of certifier



ans.

Deputy

America Ct.

29c. License number

29d. Date signed (Month, Day, Year)

- V 2 - 25

Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ELIZABETH 1150 AM A. HAMILTON VAN 02 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth HOW ARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) Days Months 1 M 2 F 9/01/12 219-12-7199 87 Maryland Usuai Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits XXYes 2 No Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ridge Circle 21044 10848 Faulkner USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 ONo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Walter Buckmaster Ida Hardesty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Murray Hamilton/spouse 10848 Faulkner Ridge Cir., Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burlai 2 Cremation 3 Removal from State So. Memorial Gdns 1/5/00 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raymond-Wood Funeral Home 21. Signature of Funeral Service Licent 00 P.O. Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final ASPIRATION 3 HOURS disease or condition resulting in death) Due to (or as a consequence of): 0158358 YEARS YARKINSON'S Due to (or es e consequence of): YEARS DEMENTIA Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

pull

certificate

this

24 hours after death.

within 2 To the I \$

pletely

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attanding Physician:

Hospital

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

mast be notified at

Nema 2

"natural", or item

the Medical

Hygiene.

.. Pages 1 and 2 should be filed v tm ent of Health and Mental Hygie tant: If itam 27 is marked other t jury or other traumatic avant, to

Department of Important: If any injury or

å,

with

filed within 72 hours after

21215-0020

altimore, Maryland

Director

Funeral

þ

Completed

Be

Examiner burial-transit the 98 USB signed by the atter page 2 funeral director, Certification: To filled in by

Physician/Medical Completed by Be

edical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

1 Yes 2 No

27. Menner of Death

1 Naturai

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and hije of certifier

FRANCIS

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Place of Deeth (Check only one)

25. Was case referred to medical examiner? Hospitai: 1 Inpatient 2 RR/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigetion 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

1 Yes 2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

mudian no 30. Name and address of person who completed cause of death (item 23a) (Type, Print) CHUIDIAN

PATUYENT PARKWAY 10724 617725

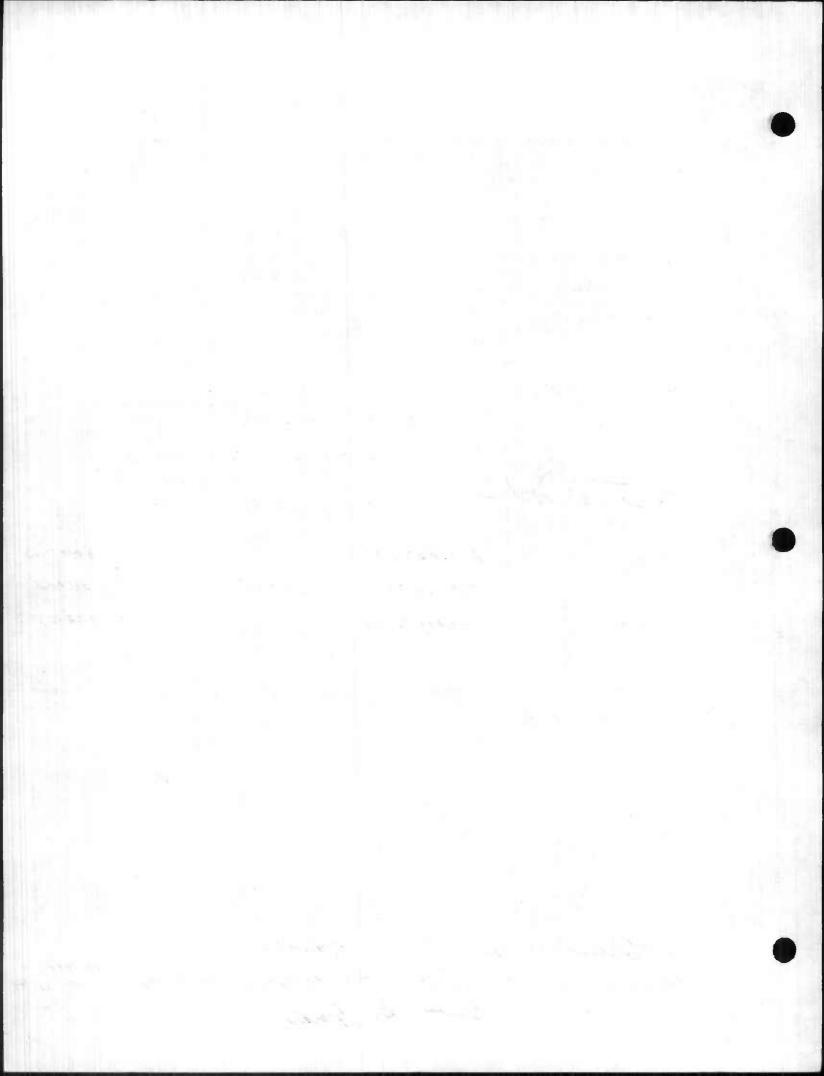
1142892

COLUMBIA MO 21044

1 Yes 2 No

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 04 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HINDMAN, Michael George Sr. January 2000 10:30 a.m. 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street and number) 4c. County of Death 1350 Lower Marlboro Road Huntingtown Calvert If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 M M 2 F Deys 44 Yrs. April 18,1955 Cheverly, 212 66 6246 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Calvert Huntingtown Maryland 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Numbe 20639 USA 1350 Lower Marlboro Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1976-77 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) driver, equipment operator concrete plant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hackley Hindman Ruth Tee Walker

same as # 10 above

Southern Memorial Gard. 01-07-00

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

23e. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pre-cause on each line.

Due to (or as a consequence of)

Due to (or as a consequenca of)

Gliosarcoma

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rausch Funeral Home, P.A., Owings, MD 20736

permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 2 with Injury or other traumatic event, the Mod call Examination and page. Physician /Medical **Examiner**

that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. Stete

12

20a. Method of Disposition

Immediate Cause (Final

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

William

Donna Jean Hindman | wife

1 Burial 2 Cremation 3 Removal from State

V

George

Funeral

Director

r 28a-f show

Directo

Funeral

þ

Completed

Be

P

the Maryland

Baltimore, Maryland 21215-0020

Examiner sician end buriel-transit attending physician for use es the burie edical 88 Physician/M signed t by Completed page 2 s director, Be 9 funeral

certificate

this

After

completely

after death.

or Attending Physician:

Hospital 24 hours

, VA

To the P within 2

27. Manner of Death Certification: 1 Natural 2 Accident 3 Suicide filled in by 4 Homicide 29a. Certifier Medical

disease or condition resulting in death)

(Check only one)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Was cese referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated.

29c. License number 3

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20c. Location - City or Town, Stete

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 A Residence 8 Other (Specify)

26. Place of Death (Check only one)

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 2 No

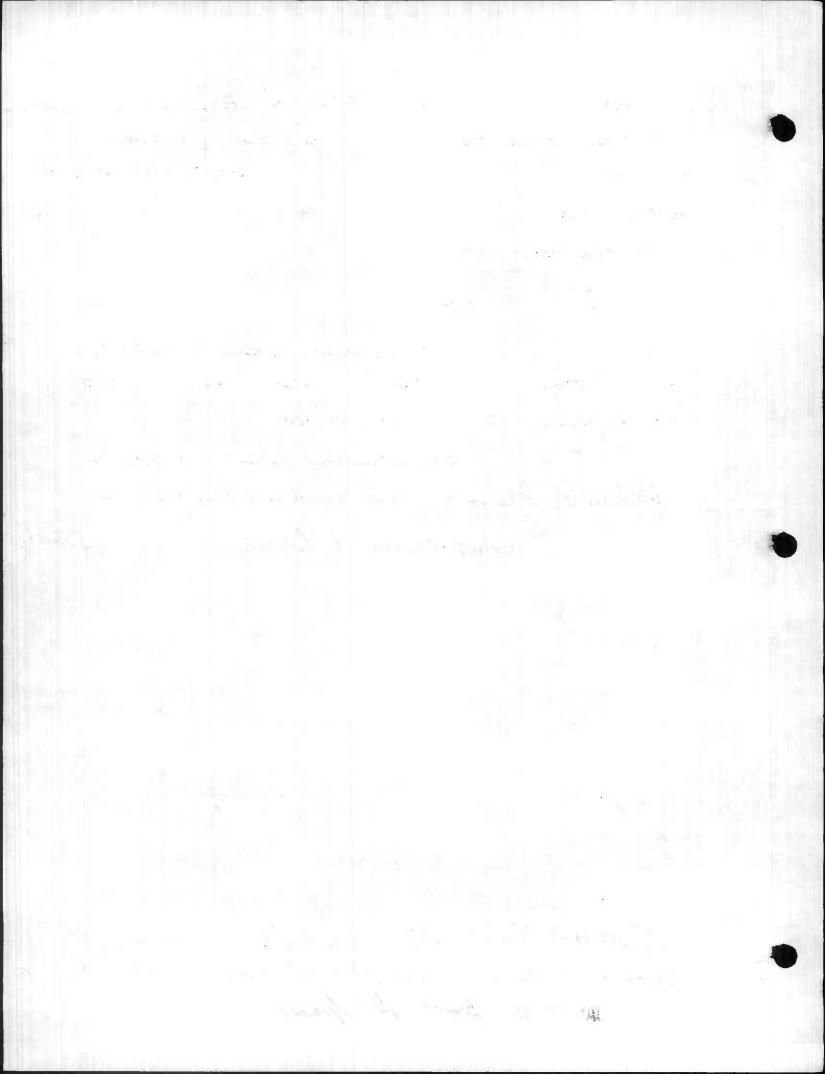
MOUTY

Dunkirk,

39 Name and address of person who completed cause of death (Item 23a) (Type, Print) tal Rd. Bring Frederick, 40 206 79

State Registrar

32. Registrar's Signature JAN 0 4 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Barbara Jean Hicks

O-ALC:	4	5 D 46
(. OPTITIE	are o	f Death

			C	ertificate	e of	Death			Reg. No.	U	11481	
	1. Decedent's Name (First, Middle, L	ast)						2. Date of De		Make	3. Time of Death	
Physician	Barbara	J.	Hicks	5				Januar	v 01	2000	05:48 PM	
/Medical Examiner	4a Facility Name (If not Institution, g	ive street and number)				4b. City, Tow		cation of Deat		nty of Death		
LAUIIIIIICI	Prince Geo	rge's Hosp	ital Cent	er	7	Ch	ever	·lv	Pri	nce Ge	eorge's	
neral		Sex 7. Ag	e (In yrs. last birthd	ay) If Under		If Under 2	24 Hrs.	A Date of Bir	th	9 Righ	place (State or Foreig	
ctor	420-66-1911 Usual Residence of Decedent	1□M 2ÅF	52 Yrs	Months	Days	Hours	Min.	Sept.	30°, 19	47 %	labama	
	10a. State 10b. County		10c. City, Town or	r Location				-			10d. Inside City Limits	
r 28a-f show r notified at irector											1 ☐ Yes 2 🛣 No	
Directo	10e. Street and Number			10f. Zip	Code				10g. Citizen o	of Whet Cou	ntry?	
	330 Crescent La	me #111				678				SA		
Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S. 1	3. Was Deced It Yes, spec	ent of I	Hispanic Orig	in? (Spe	cify Yes or No Rican, etc.))- 14. F	lace - Ameri		
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:										
Completed	15. Decedent's I (Specify only highest g		16a. De	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				ng	16b. Kind of			
dmo	Elementary/Secondery (0-12)	College (1-4or 5	i+)	e <i>DO NOT</i> us inistra					reder	ar Gov	vernment	
	17. Father's Name (First, Middle, Las	it)			18. Mother's Neme (F				, Maiden Sum	ame)		
To Be	Arno1d		Cook	18. Mother's Neme (First, Middle, Maiden Surname) Ook Lucy Tucker							c	
	19a. tnformant's Name/Relationship Alfred Hicks, Jr.		_				or Rural Route Number, City or Town, State, Zip Code)					
	20a, Method of Disposition		20b. Place of Di	sposition (Nan	ne of		20c. Location - City or Town, Stata					
	1 Burlal 2 Cremation 3 4 Donation 5 Other (Spec		Ernesti		s C	emeter	1		Chesapeake Beach, MD			
d	21. Signature of Funeral Service Lice	ensee		22. Name an	d Addre	ess of Facility	Sewe	11 Fun	eral H	ome		
y.	bled a	Luca Do									, MD 20678	
ician/Medical Examine												
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did	lb. Did tobacco use contribute to the cause of death			
								1 Yes 2 No 3 Probably 4 Unknown				
Completed by									an autopsy ormed?	8	Vere autopsy tindings vailable prior to ompletion of cause f death?	
E								145	Yes 2 No	1	Yes 2 No	
0	25. Was casa reterred to medical					26. Place	of Death	(Check only				
0	examiner? 1 X Yes 2 No	Hospitel: 1 ☐ Inpatie	ont 2774FR/Outpa	tient 3□ DC	A OI	hor				Other (Spec	i(v)	
ifer death. Niector: After this in by the funeral of interest of	1 New 2 No No Notice 1 Inpatient 2 Revidence 8 Other (Specify) 27. Menner of Deeth 1 Netural 5 Pending Investigation 28. Date of Injury 28b. Time of Injury 1 New 2 No No Notice 28c. Injury at Work? 1 Netural 5 New 1 New 2 New 1									truck fix		
Medical Ce		hysician: To the best of miner; On the basis of and manner sta	examination and/o									
2	29b. Signature and title of certifier			290	. Licen	se number			29d. Date sig	ned (Month	, Day, Year)	
	110	11 /6 -01	/		0.	C.M.E			Janu	arv 3	, 2000	
	30. Name and address of person who		eath (Item 23e) (Ty	pe, Print) 111 Per				ltimore				
	THEODORE		rie Clanetura			4	,		-, IMI	Luna		
State Registrar	31. Date filed (Month, Day, Year) JAN 0	7 2000 N	Signature	B.	de	rocks	/					

Please Type or Print in Black Indelible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 03:46 A.M Mildred Jeanette Hoover JANUARY 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Fallston General Hospital Fallston If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 16, 1913 If Under 1 Year Months Days 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2 T Maryland 86 Director 214-22-6059 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow must be notified at 1 ☐ Yes 2 No Director Maryland Harford Fallston 10g. Citizen of What Country? 10e. Sfreet and Number 10f. Zip Code 21047 IISA 2801 Harford Road 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Noms 2 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Merital Stetus than "natural", or item the Medical Examiner Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Give 1 Never Married 2 Married 21215-0020 1 Yes 2K So Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H Be Esley Eldora Kyle Carl Elijah Guyton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 7905 Rolling View Ave., Parkville, MD 21236 Rachel Coffman / Daughter Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 10℃ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Sog@ly) 5 Other (Spgtily) Air Memorial Gardens 1-8-00 Bel Air, Maryland of Funeral Service Vice 22. Name and Address of Fecility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 23a. Part I Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. **Physician** /Medical Immediete Cause (Final Congestive heart tailure 14 hours diseasa or condition resulting in death) Examiner Due to (or as a consequence of): 48 hours infarction Acute myocardial The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Coronary antery disease Box 68760. loyears Physician/Medical the Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Chronic lymphocytic leukemia Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: 25. Was case refarred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation Naturel 2 Accident or Attending 1 Yes 2 No death. 24 hours after deat Puneral Director: 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, atreet, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certitier within 24 hor To the Fune completely fi (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muhail n. Diossner M.D. January 6, 2000 D32288

State Registrar

4

DKED

HOOVER

DHMH 16 Rev 6/95

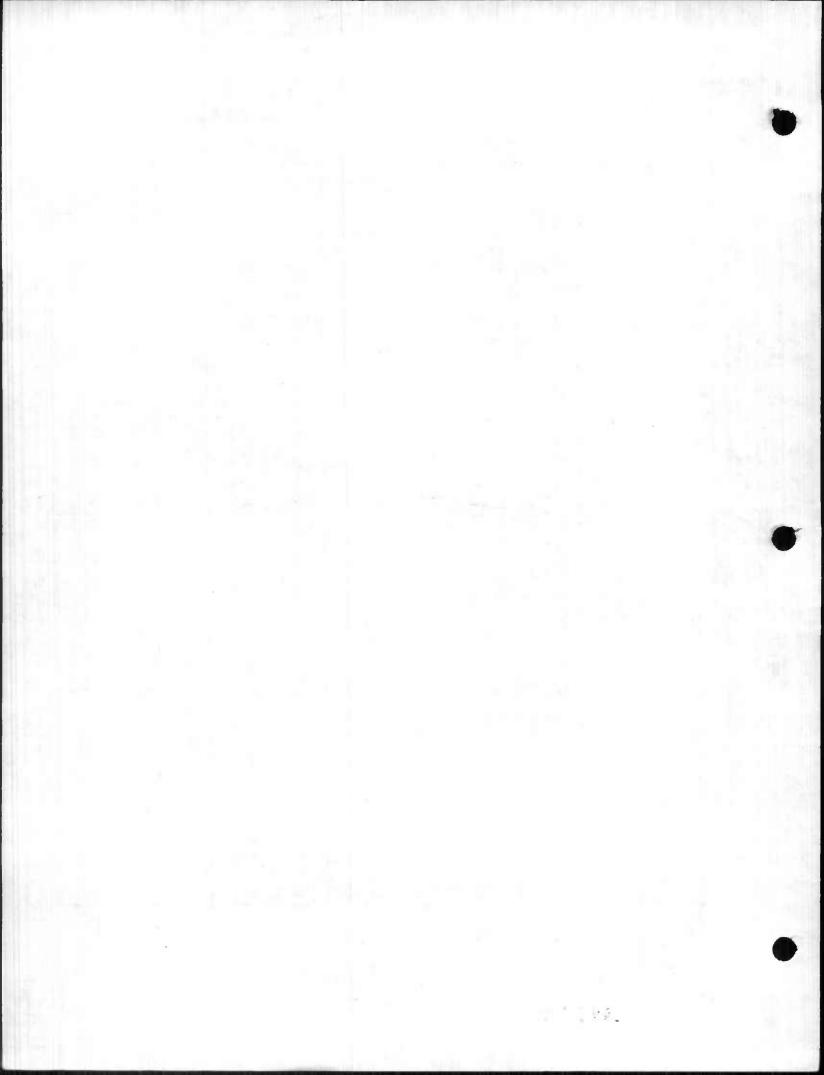
31. Dete filed (Month, Dey, Year)

Michael N. Orossner, MD, 104 Plumtree Road, Svite 110, Belfir, Maryland 21015

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

JAN 0 7 2000

32. Redistrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Veni atherine M. 12:45 A.M tage Jan. 2000 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care Krince ineview linton Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Days 1□M 28 F Months 199.14.968 97 Yrs. PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince Georges MD. Clinton 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 13102 Cherry Road 20735 United States
14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Biack, White, etc. 1 ☐ Yas 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Cottege (1-4or 5+) Sales Clerk Retail 6 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Joseph Daley Joanna Dodd 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Brons (Daughter) 20735 13102 Cherry Rd. Clinton, MD. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removat from State 4 □ Donation 5 □ Other (Specify) Jan. 4th Memorial Shrine Park 2000 Caverton, PA. 21. Signature of 22. Nama and Address of Facility Lee Funeral Home 23a. Part1. Enter the diseas shock, or heart failure. The caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, 20735 Approximate Interval Between Onset and Death . ANTERIOSCUELOTIC CAADLOVASCULAR immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequance of) Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 5 Pending Investigation 1 Maturei 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Physician /Medicai Examiner certificate be executed physician and the burial-trans

attending physician for use as the buria

been signed by the s should be detached

certificate has

After this the funeral

Attanding

death.

To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the f

USB BS

Examiner

Physician/Medical

à

Completed

Be

2

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

ð

Be

Funeral

Director

ahow

r than "natural", or items 23a or 28a-f ahov The Medical Exempler must be notified at

Hygiene.

Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked or

other

ò permit. Page Department of Important: If any Injury or once.

other

death with the Maryland

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

4 Homicide

6 Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signatura and title of certifier

29e. Certifier

30. Name

The Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

State Registrar

Miserary MD 31. Date filed (Month, Day, Year)
JAN 0 4 2000

12070 32. Registrar's Signature

eddress of person who completed cause of death (Item 23e) (Type, Print)

OLD LINE CENTER WALDERF, Md. 20602

The same of the sa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dey **Physician** HOWARD ELIZABETH JANUARY 4, 2000 8:00 pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES ADVENTIST HEALTH CARE CLINTON If Undar 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JULY 27, 1 9. Birthpiece (State or Foreign **Funeral** Months Hours Deys VIRGINIA 1908 Director 579-30-9634 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No Director PRINCE GEORGES CLINTON MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? thems 23s or U.S.A. 10404 OURSLER PARK DRIVE 20735 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, atc. 72 hours after ☐ Yas 2 ☐ No Yas, Give A 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yas 2 ☐ No Specify Specify: À BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC N/A 8 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme Be Pages 1 and 2 should be nent of Health and Mental 10 NOKOMUS MOON HENRY MONROE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 20735 10404 OURSLER PARK DRIVE, CLINTON, MD ARZINA GIBSON 20a. Method of Disposition 20b. Piece of Disposition (Nema of 20c. Location - City or Town, State cemetery, cremetory or other piece) 1

Buriel 2 □ Cremetion 3 □ Removel from State 1-7-00 LANDOVER. MD 4 Donetion 5 Other (Specify) HARMONY MEMORIAL PARK 21. Signeture of Funaral Service Licenses 22. Name and Address of Facility.
TAYLOR S FUNERAL HOME 20001 NORTH CAPITOL ST., NW WASHINGTON, DC 23a. Part1. Enter the disaesa, or complication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heert felture. List only one cause on each line. Approximete Intervel Between Onsat and Daath **Physician** /Medical Immediata Cause (Finel diseasa or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in deeth) Last Due to nsequence of P.O. Box 68760. Physician/Medical been signed by the s should be detached Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records. py 24b. Were eutopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of deeth? 1 Yes al No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Plecy of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this s 27. Menger of Death 28e. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending Investigation deeth. 2 □ No 1 Yes 2 Accident after deeth 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

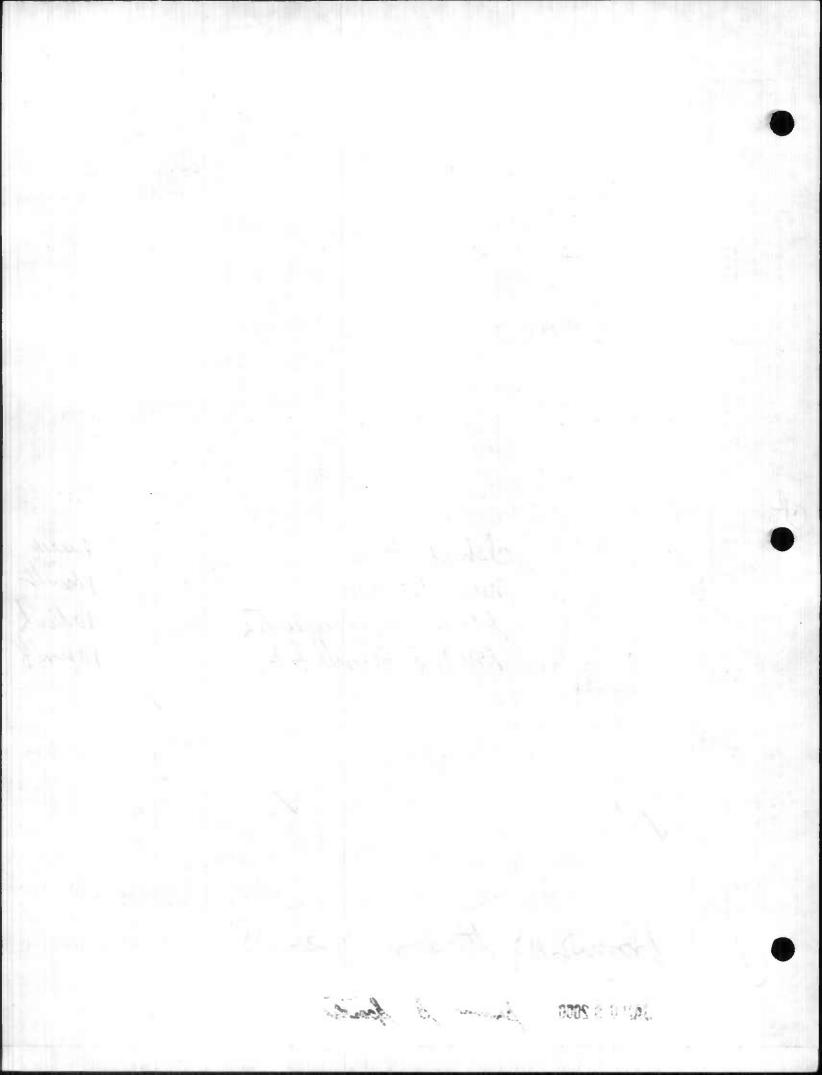
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier o the the th 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)
JAN 0 6 2000

DR. LAXMI BERWA - 7700 OLD BRANCH AVE., SUITE #101 CLINTON, MD 20735

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Month William . A. Horman, Sr. 5:15 p.m. 3, 2000 January /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠ M 2□ F Yrs. 577-03-8448 83 Director Jan. 21, 1916 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ♥ Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5602 Gallatin Street 20781 U.S.A. death v Funeral 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 🖔 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) U.S. Postal Service Carrier U.S. Postal Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic avant place. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be William Horman Marguerite Lewis 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Josephine S. Horman - Wife 5602 Gallatin Street, Hyattsville, MD 20781 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 01/05/00 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility
Gasch's Funeral Home, P.A. 0 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 3 DAYS diseese or condition resulting in death) FNAL Examiner Physician/Medical Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Box 68760. that initieted events resulting in death) Last Due to (or as e consequence of): 950 P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown NTBODIE Records, Completed by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? PNEWMONIA BEMGN 1 Yas DE No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Unpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 3 DOA 2 ER/Outpatient this 27. Menner of Death 28e. Date of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred is after death.

Director: After to by the funers After 5 Panding investigation Neturel injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours Hospita 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e Certifier To the Hosp within 24 hox To the Fune completely fi 29c. License number 29d. Detersioned (Month, Day, Year) 29b. Signeture and title of certifier cen w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, Maryland 20785 Linda Green, M.D. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar JAN 0 6 2000

MAN 5 2000 John O. Marke

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1 4 8 6

			Ce	ertificate of	Death		Reg. No.	01400		
Dharaisina	1. Decedent's Neme (First, Middle, L.	nst)				2. Data of De Month	eth Day	3. Time of Death		
Physician /Medical	DAU	XUAN HOANG				JAN.1,	2000	0315		
Examiner	4a Facility Nama (If not Institution, gi	va street and number)			4b. City, Town, o	r Location of Deat	4c. County	of Death		
	SHADY GROVE				ROCKVI			GOMERY		
Funeral Director		Sex 7. Aga (/ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n yrs. last birthday 8 Yrs.	Months Days	If Under 24 Hi	n (Month, Da	th ly. Year) 4,1911	9. Birthplaca (State or Foreign Country) VIET NAM		
urs after death with the Maryland air, or itsers 22s or 28s-f show Examiner must be notified at by Furneral Director	10a. State 10b. County MD • MONTGOI		10c. City, Town or Location ROCKVILLE 10d. Inside City Lim 1 0 Yas 2 □							
	10e. Street and Number 7501- EPS	ILON DRIVE		10f. Zip Code 20855			10g. Citizen of V USA	Vhat Country?		
	11. Marital Status 1 □ Nevar Married 2 □ Merried 3 □ Myridowed 4 □ Divorced	12. Was Decedant Eva Armed Forces? 1 Yes 20 No If Yes, Give Year or Detes:	r in U,S. 13	. Was Decedent of I If Yas, specify Cub		(Specify Yes or No erto Rican, etc.)	14. Race Blace Specify	e - American Indian, ck, White, atc.		
d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumetic event, the Medical Exam To Be Completed by I	15. Decedent's E (Specify only highest gr	ducation ada completed)	(Giv	edent's Usual Occur e kind of work done	during most of w	orking	16b. Kind of Bu	usiness/Industry		
mpl mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)		GT 0			
	7th 17. Father'a Name (First, Middle, Las	1)	TE	AILOR	18. Mother's N	eme (First, Middle,	CLOTI			
Mental H Mental H affic ever To Be	KHIET HOANG					N BUI				
od 2 shou illt and M 27 is mar r traumat	19e. Informent's Neme/Reletionship NANCY BARLOW-1		1111				ural Route Number, City or Town, State, Zip Code) , ROCKVILLE, MD • 20855			
Pages 1 a ant of Hea nt: if Itam: ry or othe	20a. Mathod of Disposition 1 XBuriel 2 Cremetion 3 [4 Donetion 5 Other (Speci	Removel from State	cematery, cr	of Disposition (Name of terry, cremetory or other place) RGE WASHINGTON CEM1/6 ADELPHI, MD.						
Departm Departm Imports any inju	21. Signature of Funerel Saville Lice	HOME								
Physician /Medical Examiner	23e. Pert1. Enter the disease, a shock, or heart failure. Life of Immediate Ceuse (Finel disease or condition resulting in death)	Due	icular e to (or as a conse	arrythm	ia	ac or respiretory e	rrest,	Approximate interval Between Onset and Death days		
eath certificate be assected attending physician and for use as the burlet-transit clan/Medical Examiner	Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence of):									
the attention the deriver	Part II. Other significant conditions	contributing to death but n	ot resulting in tha	underlying cause gi	ven in Pert i.	23b. Did	tobacco use cor	ntribute to the cause of death?		
that the detac	Thrumbocy	copenia	10	1 Yes 2 No 3 Probably 4 Unknown						
aw requires to been so 2 should pieted	Aplastic a	anemia				24a. Was perfo	24b. Ware autopsy findings available prior to completion of cause of death?			
The law ate has page 2						101	Yes 2X No	1 Yes 2 No		
ysician: The sis certificate director, pag fo Be Co	25. Wes case referred to medicat axaminer?				26. Place of D	eath (Check only o	one)			
S Sip O	1 ☐ Yes 2 ☐ No	Hospitel: 1 Inpatient	2 ER/Outpatio	SILL SEL DON		Home 5 ☐ Resi				
Ing After fune fune	27. Menner of Deeth 1 [XNetural 5 Pending 2 Accident investigation 3 Suicida 6 Could not be	n	28e. Dete of Injury (Month, Day Year) 28b. Time of Injury M 28c. thjury at Work?				how injury occurr			
ttaf or Att ins after of raf Direct iled in by	4 Homicide determined	28e. Pleca of Injury building, etc. (S	At nome, ferm, s Specify)	treet, rectory, office		28f. Location (wn, Stete)	er or Rural Route Number,		
To the Heapital or Attand within 24 hours after death To the Funeral Director: complately filled in by the Medical Certificat	29a. Certifier (Check only one) TO Certifying PI 2 Medical Example 1	nysician: To the best of m miner: On the basis of exa and manner stated	aminetion end/or i	nvestigation, in my	opinion, deeth oc	ce, and due to the curred et the time,	cause(s) and ma date end plece,	nner as stated. and due to the cause(s)		
within 2 To the compla	29b. Signeture and title of certifier	A BAll	MD	29c. Licens	53317		29d. Date signed (Month, Day, Year) 1/1/2000			
(2)		A. BALL- 1	6220-SI		VE RD.	, SUITE	213,G	AITHERSBURG, M		
State Registrar	31. Data filed (Month, Dey, Year) JAN 0 5 2000	32. Registrer's	Signeture 4.	Sports	,					

1RN V S 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Otate of Marylai		te of Death		ng. No. 0 0	01487			
Physician	Decedent's Name (First, Middle, Last				2. Date of Deat Month	Day	Year 000 9:55AM			
/Medical	Betty E. Har 4a Facility Name (If not institution, give			4b. City, Town, or	Januar Location of Deeth	4c. County				
Examiner	Heartland Heal		attsville	Hyattsv			nce George's			
Funeral Director	5. Social Security Number 6. Se 579-12-0717	7. Age (in yrs.	Months	or 1 Year If Under 24 Hrs Days Hours Min.		, 1909	9. Birthplace (State or Foreign Country) Virginia			
death with the Maryland the 23a or 28a-f show Linust be notified at neral Director	10a. State 10b. County 10c. City, Town or Location 10d.									
	10e. Street and Number 1448 Monroe St.,	N.W.	10f. Zi	20010	10	Og. Citizen of W	hat Country? ed States			
- 2 2 2 7	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:	100000000000000000000000000000000000000	dent of Hispanic Origin? (Socity Cuban, Mexican, Puerl	specify Yes or No- to Rican, etc.)		e-American Indian, k, White, etc. . Negro			
72 ho matural dical	15. Decedent's Edu (Specify only highest grad	leation le completed)	16a. Decedent's Use (Give kind of w	ual Occupation ork done during most of wo use retired)	rking	16b. Kind of Bu	siness/Industry			
1 21215-0 ed within 72 ho yglerin. we than 'natum it, the Medical.	Elementary/Secondary (0-12) 5th	College (1-4or 5+)		ose retired) Clerk		Government				
Ind 2	17. Father's Neme (First, Middle, Last)				me (First, Middle, A					
Alected of the save after save af	Willie Farrar				Annie She	1ton				
, Maryland 21215-0020 and 2 should be filed within 72 hours at alth and Mettal Hygieria. 27 is married other than "natural", or ar traumatic event, the Medical Exam To Be Completed by F	19a. Informant's Name/Relationship (7) Dorothy Faison		ural Route Number . Wash.,		State, Zip Code) 20010					
altimore mit. Pages 1: partment of Ne portent if Ihem y Injury or othe	20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Specify)	Removel from State	Place of Disposition (Na cometery, crematory or Lincoln Mem	other place)			ation - City or Town, State			
Balti permit. Departiments any inju	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Stewart Funeral H 4001 Benning Rd., N.E. Wash., D.									
Physician /Medical Examiner	23a. Pany Linter the disease, or complete the disease, or complete the disease or condition resulting in death)	ANTEN		De CANDION			Approximate Intervel Between Onset and Death He Y-Lans			
68760, filicate be executed g physician and as the buriel-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c								
death certific death certific e ettending i ed for use as		d								
. 0 0 2	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying	cause given in Pert I.	23b. Dld 10	bacco use con	tribute to the cause of death?			
				1 🗆 Y	1 Ves 2 No 3 Probably 4 Tonk					
S been 2 should				24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?				
The land the					1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No			
Of Vital Physician: The Physician: This certificate rail director, page 1: To Be Co	25. Wes case referred to medical examiner?	Monital:								
on of Aller this of Numbers direction: To	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)		OA 42/Nursing P 28c. Injury at Work? 1 Yes 2 No	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
Division of Hospital or Attending P 24 hours after deeth. Funeral Director: After tely filled in by the luners licel Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fectory)		l. Location (Street end Number or Rural Roule Number, City or Town, Stele)					
Hospi 24 hours Funer Hely fill		sician: To the best of my kno ner: On the basis of examina and manner steled.								
To the within 2 To the comple	29b. Signature and title of certifier	11		Oc. License number	2	9d. Date signed	i (Month, Day, Year)			
	Fundlin	Levorli		1)0103	52.	TANUI	1RY 6,2000			
(3)	AND A. DEV	ompleted cause of death (Item OPE MO Y	m 23a) (Type, Print) 203 (DU A	pensbury.	Rel H	pe too!	1/e ay 2000			
State Registrar	31. Date filed (Month, Day, Year) JAN 0 7 2000	32. Registrar's Sign	die Soor	h						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month 9:10 A.m January Anna Olive Haina 6 2000 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 1 F 212-14-2874 Yrs. 88 1911 Maryland June Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Md. Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7996 I Silentwinds Court 21061 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 X No If Yas, Give Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper US Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) William A. Smith Ida Gentry 19e. tnforment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Haina - Son 10200 Angora Ct., Cheltenham, Md. 20623 20b. Plece of Disposition (Neme of cametary, cremetory or other place) Valley View Cemetery 20e. Method of Disposition 01-08-0020c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Nokesville, VA 21. Signature of Funeral Service Licent 22. Name and Address of Facility Beall Funeral Home Robert G. Beall M00025 6512 N.W. CRain Hwy., Bowie, Md. 20715 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximata Interval Between Onset and Death Immediete Cause (Final DNEUMONIA diseese or conditio resulting in deeth) IELO DYSPLASIA Sequentially list conditions, if any, laading to immedieta cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 32 No 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 29 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yas 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, etreet, fectory, office building, etc. (Specify)

The law requires that the death certificate be executed the burial-transit Box 68760, USe esu P.O. Division of Vital Records, page 2 certificate or Attending Physician: After this s after death.

Physician/Medical

þ

Be Completed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show Inotified at

b

238

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be nant of Health and Ments! int: If Hers 27 is marked o

Physician /Medical

Examiner

Directo

Funeral

ğ

Completed

Be

Medical Certification: To filled in by 24 hours a Hospital within 2 To the \$ 0 State

Registrar

29b. Signeture and title of certifier

4 Homicide

(Check only one)

29a. Certifier

ms)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted.

29d. Date signed (Month, Day, Year) 2000

Burne. no. 21061

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

301 Maritz

32. Registrer's Signeture

JAN 0 7 2000

31. Dete filed (Month, Dey, Year)

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 20000753 leresA JONES 02 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Deeth Burnice 1405 DITAI (glen runde If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF 53 579-62-0134 19, 1946 Wash., **Usual Residence of Decedent** 10n. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYes 2 No Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5424 - 55th Place #203 20737 United States 14. Race - Amarican Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Stacey Prince, Sr. Esther Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Eurania Douglas - Daughter 3105 Reiner Ct., Temple Hills, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 1/12/2000 Clinton, MD of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart feiture. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediata Cause (Final disease or condition resulting in death) Preumouix Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): DS LINKNOWA Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Minknown 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axis priner? 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or hame 23a or 28a-f ahow the Medical Examiner must be notified at

Director

Funeral

þ

Completed

8

with the Maryland

filed within 72 hours after death

permit. Pages 1 and 2 should be filed within 7. Department of Health and Meniel Hyglene. Important: if Item 27 is marked other than "na eny injury or other traumatic event, the Menia page.

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

of Vitai

Division

Examiner Physician/Medical by Completed 8 Certification: To

physician and the burial-transit The law requires that the death certificate be executed d for use as signed by the e page 2 s has Attending Physician: this After t To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu r deeth.

edical State

29b. Signature and title of certifier

11 Am 31. Date filed (Month, Day, Year) JAN 0 6 2000 Registrar

TNYes 2□ No

5 Pending investigation

6 Could not be determined

Manner of Death 1 DNatural

2 Accident

3 ☐ Suicide

4 I Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Deputy

28a. Dete of Injury (Month, Day Year)

1 ☐ Inpatient 2 Ø ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number D 06054

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Routa Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

and address of person who complete cause of death (Item 23a) (Type, Print)

ONES m 32. Registrar's Signature

Stace

Eurania Doug.

John T. Steward,

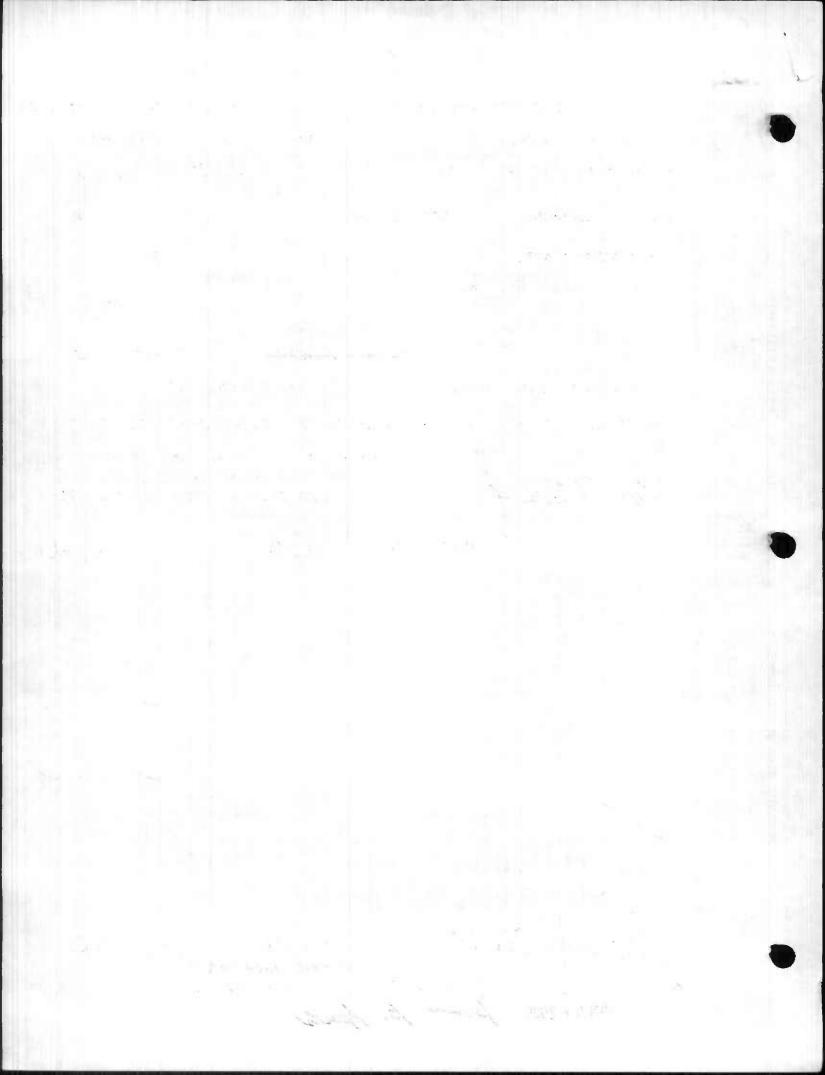
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

Amended Item 16a, per F.D.

State of Maryland / Department of Health and Mental Hygiene

706/2000,	carroir cour	icy, wji			Ce	rtificate (of L)eath			Reg. N	lo.		1 1 7	20
Physician /Medical			RLOTTA		LAMBEF	RT				2. Date of Do Month JAN.		200	Year 0		e of Death
Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. Coun								ARROLL						
Funeral Director	5. Social Security 219-56-	-3048	Sex 1□M 2∏XF	7. Aga (In yrs	. last birthdey) Yrs.	If Under 1 Y Months De		If Under: Hours	24 Hrs. Min.	8. Dete of Bi	8. Dete of Birth Morth, Dev. Year) 1 0 / 2 / 1 9 5 0				
the Maryland 23a-1 show notified at rector	Usual Residence	10b. County CARR	OLL		ity, Town or Lo										a City Limits
Maryland 21215-0020 3 2 should be filed within 72 hours after death with the Ma th and Mental Hygiere. 7 is merked other than "natural", or items 23s or 22e-1s trauments event, the Medical Examiner must be notifile To Be Completed by Funeral Director	10e. Street and No	umber				10f. Zip Co	de				10g. C	Citizen of \	What Cou	intry?	
	209 SH	AEFFER	AVE			211	57	,				USA.			
	11. Maritel Status 1 □ Never Mai	ried 2 Married	12. Was De Armed F	cedent Evar In I Forcas? 2 M No Give		Was Decedent If Yas, specify	of His Cuber		gin? (Sp n, Puerto	ecify Yas or N Rican, etc.)	0-	14. Rac	t. Race - Americen Indien, Black, White, etc. Specify: WHITE		
bed within 72 hours ygiene. Then "natura ner than "natura nt, the Medical E. Completed I		15. Decedent's leading only highast g	Educetion rade completed	Education 16e. D			dent's Usuel Occupation kind of work done during most of workin DO NOT use retired) WELDER & S			ing SOLDERER		Kind of B	usin ess/i r	ndustry	
Co the	9				MELL	ER &	_	DERE			-			CTURING	
Mental H merked oth merked oth merke even	PAUI	JOHN C	ELLOSI	PEDALE	401 44 11			HEL	EN :	IRENE	НО	Meiden Sumeme) HOOPER			
ages I and clarification of Health and Lift Health and Y is m	CHARLES 20a. Method of Dir 1 🕅 Burial 2	Cremation 3	IBERT -	n State	ND 209 Plece of Dispo	SHAE: osition (Name of matory or other CEMET:	FF]	ER A	VE.		1IN:	STER Location	MI City or T	0.21 own, State	9
Departme Important any injury once		5 Other (Spec	107-27-7	1.	2	2. Name and A	ddres	s of Facilit	y FL	ETCHE	R F	UNER	AL I	HOME	
certificate be executed and inding physician and inding physician and indinational search burta-transit and indinational Examiner	Sequentielly list of if any, leading to lise seems. Enter Unc Cause (Disease of that initiated even resulting in deeth)	conditions, immediate sarlying tripiury	c	Due to	(or as a consector as	quence of):									
the deam by the atter ached for u	Part II. Other sign	ificant conditions	contributing to	death but not re	sulting in the u	nderlying ceus	e give	en in Part I	.= 1		l tobac	co use co			se of death
been sign should be										24a. Wa		topsy	a	Vere autop veilable pr ompletion f death?	
ate has t page 2 s										1	Yes	2 NO			2 No
certificate rector, pag	25. Was cese refe	erred to medical						26. Place	of Deat	th (Check only					
yaictan: is certific director. To Be (examiner?	No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Othe	DP:		ome 5 🔀 Ras		6 □Oth	ner (Spec	ify)	
ding Ph. After thi funeral	27. Manner of Dec	5 Pending Investigation	28e. Date (Mo	e of Injury onth, Dey Year)	28b. Time o Injury	f 28c.	Injury Work 1 🗆 Y			28d. Describe	how In	jury occur	rred		
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it completely filled in by the funera Medical Certification:	3 ☐ Suicida 4 ☐ Homicide	determine	d 286. Plac build	ce of Injury - At ding, etc. (Spec	eify)					28f. Location City or To	own, St	efe)			rvum <i>ber</i> ,
To the Hospital within 24 hours. To the Funeral completely filled	29a. Certified (Chack drily over)	1 Certifying P	minar: On the			vestigation, In	my op	oinion, dea			, date e	and place,	and due	to the ceu	
T V C S	29b. Signature and	d title of certified	mo	M		D 29c. Li	3°	number 53	98		1-	-6	- E	Day, Yes	31)
State	100110	nth_Day, Year)	on He	ights Registrar's Sign	em 23e) (Type,	Print) FU Stylins	te	1 N	KR4	21/5	M,D	,			
Registrar		JAN 0 6 2	2000	Dener	~ 19	· Low	EL.	11							

B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** MARTETTA FILICE LICO Jan. 2, 2000 12:05 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Prince George's Mitchellville 8. Date of Birth (Month, Day Year) 1912 9. Birthplace (State or Foreign Couptry) 1taly 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1□M ŽĚF Days Min. Months Hours 577 68 7605 87 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X⊠Yes 2□No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2250 Hindle Lane 20716 Italy Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married I □ Yas 2 ⊠ Xlo If Yes, Give Year or Dates: 1 Yes 2 XXXo by Specify: 3 Widowed 4 □ Divorced White Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Giuseppe Filice Angela LoScudo 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rose Ruzzi Daughter 2250 Hindle Lane Bowie Maryland 20716 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from Stata 20b. Place of Disposition (Neme of cametery, crematory or other place) Jan. 5, 2000 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton Maryland 21. Signature of Funeral Sarvica License 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as on each line. 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Approximate Interval Between Onset and Death enotic Heart Distance Immediate Ceuse (Final disaasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last to (or as a consequence of Physician/Medical Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yas 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homleide Medicai Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifler (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30 (fallows Fox Bowie MD

State Registrar

Director

rel', or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vient of Haalth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23

event, the Medical

traumatic

nt of Haalth a If Itam 27 is or other trai

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

the burial-transit

88

been signed by should be detac

page 2 certificate

filled in by the funeral

completely

this

Affer

s efter death.

To the Hospital of within 24 hours e To the Funeral D

The law requires that the death certificate be axecuted

P.O. Box 68760.

Records.

Division of Vital

Hospital or Attending Physician:

Baltimore, Maryland 21215-0020

with the Maryland

South the second of the second

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 02, 2000 **Physician** ANNIE E. LEWIS 9:40 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) SEPT. 01, 1919 9. Birthplece (State or Foreign Country) VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Hours 1□M 200X 223-58-4415 80 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 'natural', or hams 23s or 28s-f show edical Examiner must be notified at 10d. Inside City Limits MD PRINCE GEORGES CLINTON Director X1XXYes 2 No 10f. Zip Code 20735 10g. Citizen of What Country? STUART LANE UNITED STATES Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo if Yes, Give Year or Dates: ▼S Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X2XXNo Specify: Specify: AFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 / 3 College (1-4or 5+) HOMEMAKER PRIVATE permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If New 27 is marked other any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be JAMES LEWIS NANCY MOSBY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 929 OWENS ROAD, OXON HILL, MARYLAND DUCKETT/ NIECE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition, Date 20c. Location - City or Town, State 1 X Burial 2 Compation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature Fungel/Service Lightsee FOREST HILL CEMETERY 01-08-2000 CLINTON, MARYLAND 22. Neme and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, EDWARD M. DUDLEY MD 20712 23a Part 1. Pater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final SEPSIS DAY. disease or condition resulting in death) Examiner PNEUMONIA Examiner SPLRATION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or es e consequenca of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA by 24b. Were autopsy findings aveileble prior to 24a. Wes an autopsy performed? Completed EHUDRATION. completion of cause RENAL INSUFFICIENCY 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Certification: To 1 Yes 2 Avo 28a. Date of Injury (Month, Dey Year) 27. Manner of Death To the Hospital or Attending Provinin 24 hours after death.
To the Fureral Director: After the completely Illed in by the furera 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and menner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the fime, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 50653 1-2-2000 Print) GYAN
ROAD - 7 CHAND SUKANA 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) DEALECHURCHTON DEALE 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 0 7 2000 Registrar

CANOT DIAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 3 Time of Death 2. Dete of Death Month Physician 1, 2000 Gregory Loften Jan. 5:30 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Cheverly Prince Georges Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) NOV . 1 , 1952 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F 47 Yrs 577-68-6337 Wash.D.C. Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at D.C. none Washington 1 ☑ Yes 2 ☐ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3657 20019 B St. S.E. U.S.A. Funeral death 14. Reca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumetic event, fine Media pace. Elementery/Secondary (0-12) College (1-4or 5+) Laborer Construction 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Jones Elizabeth Loften 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3928 Suitland Rd. #202 Suitland, Md. 20746 Shouney Lee Sister 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition Muriel 2 Cremation 3 Removal from Stete Forest Hill Mem. Cem. 1/8/00 Clinton, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service License Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner we ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (pr as a consequence of) attending physician for use es the buna P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by 1 Yes 2000 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed been s page 2 certificate has Physicien: 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 10 1 Yes 2000 2 ER/Outpatient 3D DOA After this funeral 28d. Describe how injury occurred 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? or Attending 5 Pending 1 | Yes 2 | No 2 Accident within 24 hours after death. To the Funerel Director: A investigetion 6 Couid not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Dey, Year) 0 00 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State JAN 0 7 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Day, 2000 Morsell Pear1 E. 4:45 A.M. January /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner Calvert Calvert County Nursing Center Prince Frederick 7. Aga (In yrs. last birthday) 84 yrs. If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 23, 1915 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1□M 2☐F Days Hours 219-16-1565 Director Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exercises must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. XXYas 2 No Washington Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5514 Kansas Ave. NW 20011 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specity Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, Whife, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumama) John E. Mackall Aletha 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alfredia Marshall/Daughter 5514 Kansas Ave. NW Washington, D.C. 20011 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 🖾 Cremation 3 ☐ Ramoval from State 1/13/00 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Sewell Funeral Home Block 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onsef and Death Physician /Medical Immediate Cause (Finel disaasa or condition resulting in death) Examiner Due to (or as a consequence of Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Progressive DivIsion of Vital Records, P.O. Box 68760, Due to (of as a consequence of): 889 USB I signed by the a d be detached f Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes 2 No 1 Yes YE No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral D 29a. Certifier 1XX certifying Physician: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD Jonathan Lowenthal, M.D. 31. Date filed (Month, Dey, Year) JAN 1 2 32. Registra/s Signature

2000

DHMH 16 Rev 6/95

Registrar

Terrel Terrel

marin Barra

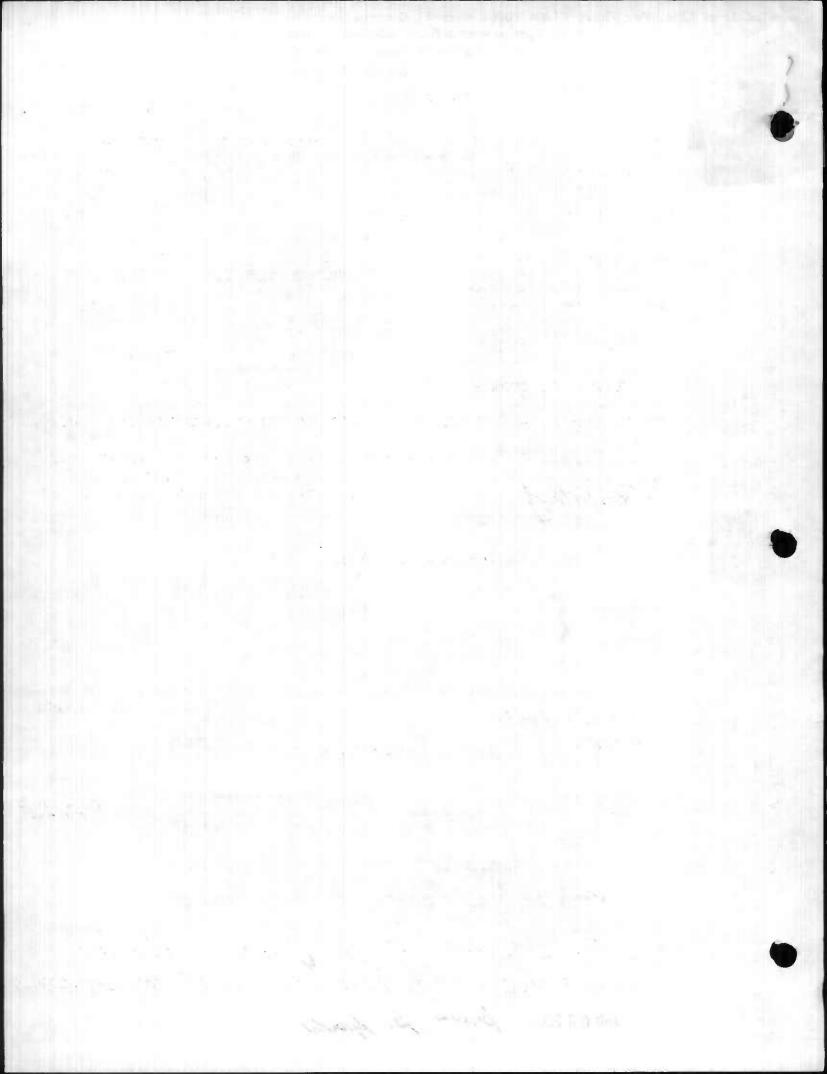
A. D. Service, C.

ATTENDED TO THE PARTY OF THE PA

EDGE FOR DA WALL DE DEAL FOR IT IN THE

Amended Item #29c, Per Phy., 01/04/2000, Carroll County, cew Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2000 Month HELEN THOMAS MCNEIR **Physician** 2, JAN. 5:00 AM. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street end number) **Examiner** 1916 OLD Taneytown Rd. WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months 1□M 2XF 94 Yrs. 213-74-7219 8/19/1905 **Director** MARYLAND Usuai Rasidenca of Dacedeni with the Meryland 10e. Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 23s-f show the Modical Examiner must be notified at MD. CITY BALTIMORE 1 Yas 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5206 ANTHONY AVE. 21206 USA. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry a filed within 7 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filled wi Department of Health and Mental Hygien, important: If tem 27 is marked other th, any Injury or other traumatic event, tra-once. 12 4 TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ALBERT J. THOMAS CLARA SEAY 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) LUCY C. MCNEIR -DAUGHTER 1916 OLD TANEYTOWN RD., WESTMINSTER, MD. 21158 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriai 2 □ Cramation 3 □ Removal from Stata MORELAND MEM. PARK 1/4/2000 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fundral Service Licensee 22. Name end Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or control ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in deeth) /Medical Examiner Examiner ettending physician and for use as the burial-transit The law requires that the death certificets be assecuted Sequentially list conditions, if any, leeding to immadiate cause. Enter Undarlying Cause (Disease or Injury Physician/Medicai that initieted events resulting in death) Lest Due to (or es a consequence of): 98 signed by the e Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 7 Deslose. 24e. Was en eutopsy performed? peen certificata has within 24 hours after death.

To the Funeral Director: After this carefred completely filled in but the transfer of the funeral precions. 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) Home Hospital: 0 1□ Yes 2□ M6 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Matural 5 Pending invastigetion 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. edicai 29e. Certifier (Check only 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) D0050763 30. Name and address of person who completed cause of death (Item/23e) Ptype, Print) ETENESTO Koad menodo 31. Dete filed (Month, Day, Year) 32. Registrer's Signature Registrar **DHMH 16 Rev 6/95**



Records, Division of Vital

111

7日

31. Date filed (Month, Day, Year) State JAN 0 7 2000 Registrar

29b. Signature end fittle of certifier

7401

rive 32. Pegistrer's Signeture

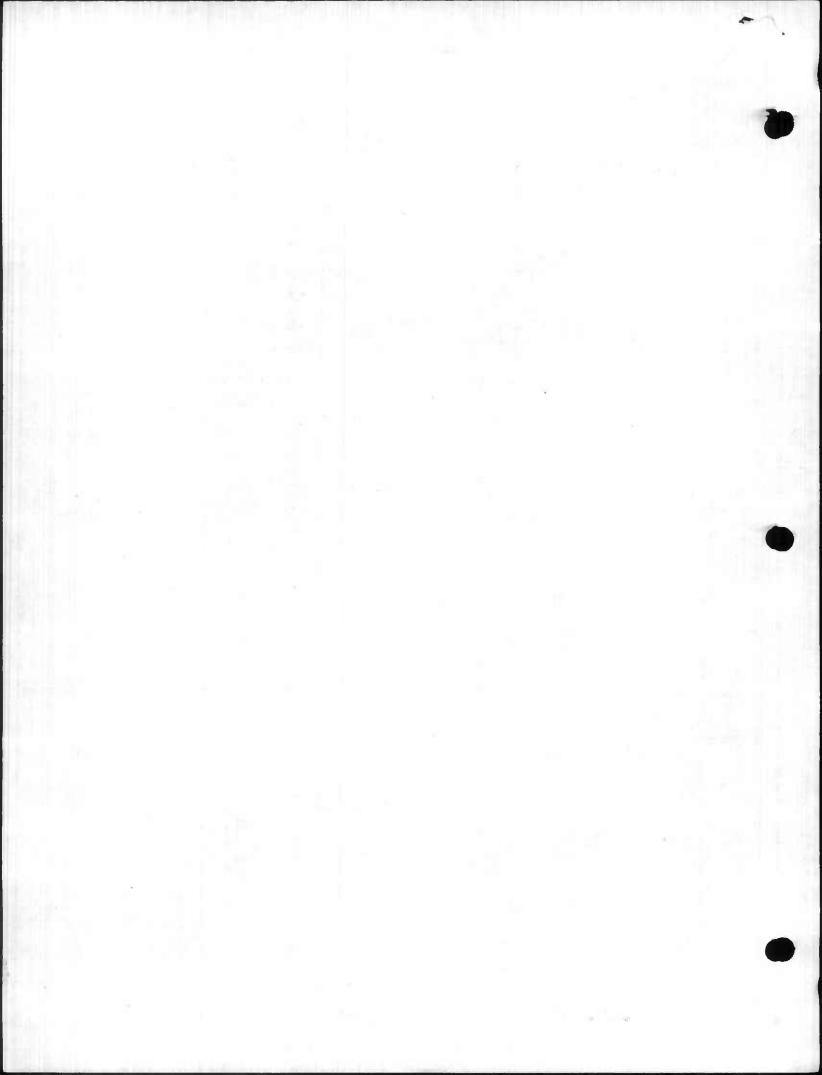
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

DWSon, MD

JUC



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** January 1450 Mary Merritt 3 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 25¥F Hours Months 81 219-07-6482 Director Sept. 24, 1918 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28s-f show must be notified at 1 ☐ Yes 2 No Director MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or thams 23s or 2113 By-Pass Road 21851 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Merital Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white à 3 ™ Widowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Food Production permit. Pages 1 and 2 should be filled Department of Health and Mental Hygi-Important: If Itam 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew J. Dashiell Julia Ford Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Woodcrest Ave., Salisbury, MD 21804 Darlene Smack (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State ò 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2000 Oriole, MD Oriole Cemetery 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 21. Signature of Fundral Service Licensee m01129 103 Linden Ave., Pocomoke City, MD 21851 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yas 2 No p 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed?

Box 68760

219-07-6482

Completed peen : page 2 certificate director, Be Certification: To this After death.

of Vital or Attending Physician: Division To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

edicai

State Registrar 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 234) (Type, Print)

H. Meyer Benjamin 31. Date flied (Month, Day, Year) JAN 0 5 2000

25. Was case reterred to medical examiner?

5 Pending

investigation 6 Could not be determined

1 Yes 2 No

27. Menner of Death

Natural

26 Accident

4 - Homicide

3 ☐ Suicide

29a. Certifie (Check only one)

legistrar's Signature

Inpatient

28a. Date of Injury (Month, Dey Year)

oaks

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

30743

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1000

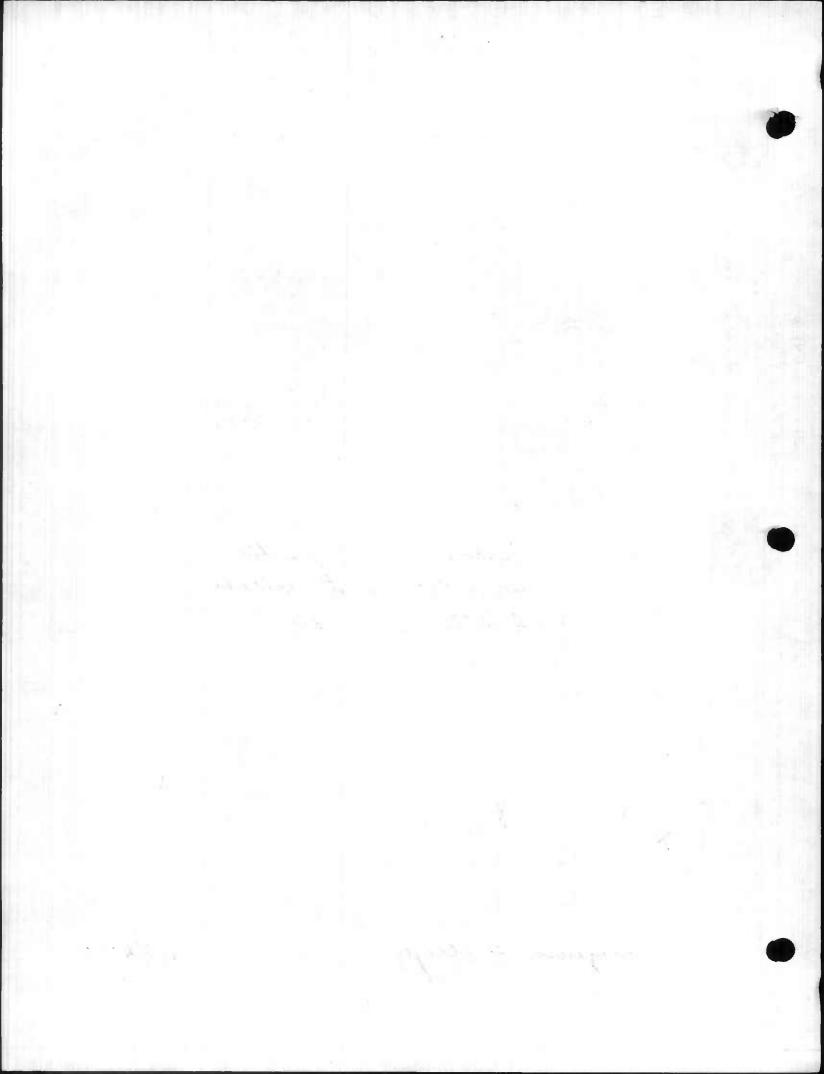
completion of cause of death?

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

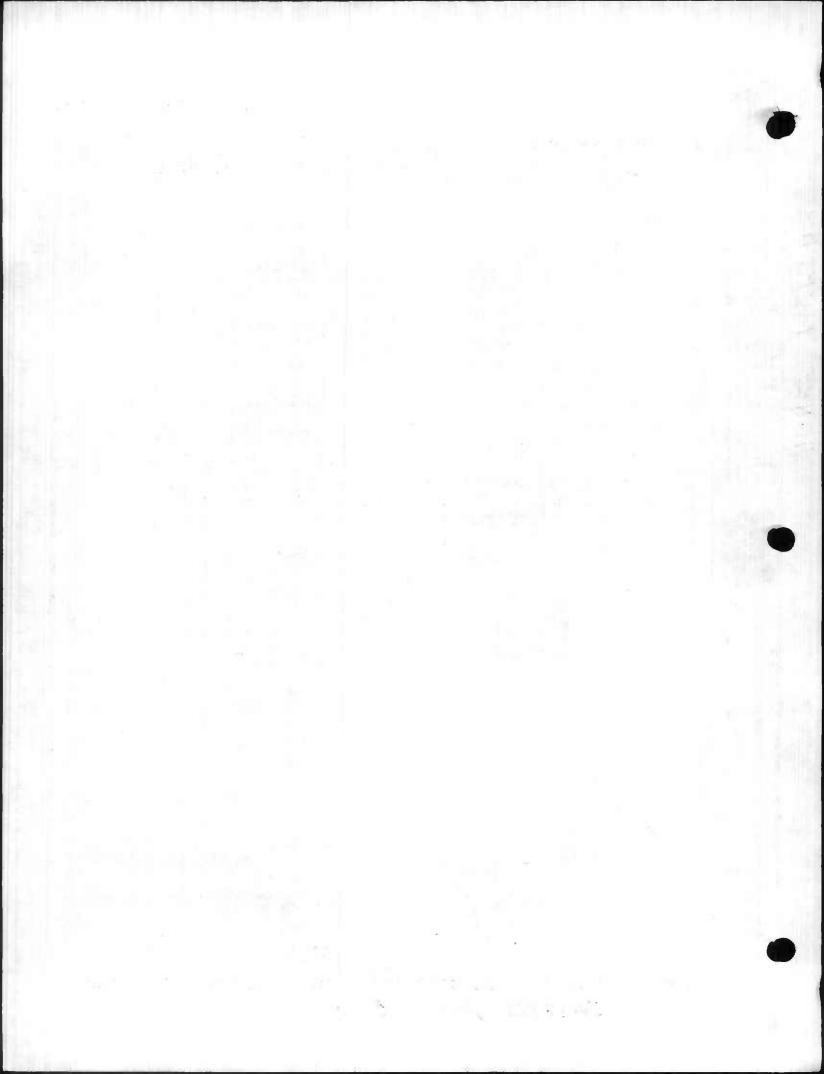


MURPHY Baltimore, Maryland 21215-0020 AGNES

Wision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be associated to be as as a second to be associated to be as a second to be	>	Phy /N Ex	ys le ai
	vision of Vital Records, P.O. Box 68760,	Attending Physician: The law requires that the death certificate be assected	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician AGNES** MURPHY **ESTELLE** JANUARY 10,2000 10:57 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER CHARLES LAPLATA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth Aug. 19,1921 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 X F Mary Pand Yrs 78 Director 214-76-5236 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No Director Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4558 Tate Street, Kings Manor 20695 U.S.A. or Nerna 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marilal Status 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: P White 3 ₩ Widowed 4 Divorced "natural". Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Is marked Robert Ford Farrell Agnes Flortine Gray 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: if Item 27 is any injury or other trau artics. P.O. Box 383, White Plains, Maryland Ethel C. Hall/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Donation 5 Othe (Specify Trinity Memorial Gardens 01-14-2000 Waldorf, Maryland 22. Name and Address of Fecility
The Huntt Funeral Home, Inc. 21. Signature MARK **BROHAWN** M00053 G. P.O. Box 156, Waldorf, Maryland mew 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ician Immediate Cause (Final disease or condition resulting in death) dical niner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached signed by I 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24e. Wes an eutopsy performed? Completed completion of cause of death? s certificate has director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to-medical Be 26. Place of Death (Check only one) Hospital: 1 Thpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 (Wature) 1 Yes 2 No 2 Accident ector: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 | Homicide To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b edicai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D-21031 30. Name end address of parson who completed cause of deeth (Item 23a) (Type, Print) LEATHERWOOD M.D. 12070 OLD LINE CENTER SUITE 202 WALDORF MD. 20602 MICHAEL A. 2000 Registra's Signeture State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health
Michael Anthony Moore	Certificate of Deat

Antho	-	Moore Decedent's Name	a (First Middle	l act)		Ce	rtificate	e of	Death	2. Date of D	Reg. No.	10 (3. Time of Death	
hysician	_									Month	Day	Year		
/Medical Examiner	4a	Facility Name (/	f not institution, g	ONY MOO	mber)				4b. City, Town, or	Janua Location of Dee		nty of Deeth	04:17	
				Hospital					Cheverl			nce Ge	eorges	
neral ector	5	Sociel Security N 77-74-3	3715	Sex 1GM 2□ F					If Under 24 Hrs. Hours Min.	8. Dete of 8 (Month, D	irth Pay, Year) 2/55	Cour	plece (Stete or Foreign ntry) 1 • D • C •	
rd at	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location								1	10d. Inside City Limits				
rector		D.C.			Was	hingt	on						Y□ Yes 2□ No	
020 urs after death with all, or items 23a or expected must be by Funeral Dil	10	Street and Nur	mber				10f. Zip	Code			10g. Citizen	of What Cour	ntry?	
		1123 Cc	ongress	s St. S	. S.E. 20032 U.S.A						.A.			
		Marital Status 1 Never Marri 3 □ Widowed	ed 2 Married	Armed Fo	2 X No		Wes Deced If Yes, spec 1 Yes 2		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)		Bleck, White,	etc.	
e te		(Spec	15. Decedent's	Education grede completed)	cation 16a. Decedent's			l Occup	etion during most of word)	rking	16b. Kind of	Business/In	dustry	
Completed		Elementary/Seco		College (1	-4or 5+)						-			
ပိ	17	Father's Name	(First Middle La	3½		BI	ag.	Eng	ineer	ne (First Middl				
o Be			ony James Moore									4,110)		
ř	-	a. Informant's Ne				10h Maili	na Address	(Street	-		10g. Citizen of What Country? U.S.A. s or No- slc.) 14. Race - American Indian, Bleck, White, etc. SpecifyBlack 16b. Kind of Business/Industry Private Middle, Malden Sumame) hnson Number, City or Town, State, Zip Code) E. Wash.D.C.20032 20c. Location - City or Town, State 2000 Suitland.Md. s and Edwards D.Suitland, MD. atory arrest, Approximate Intervel Between Onset and Death			
		Mary Mo		o (rypo, rini)										
	-	. Method of Disp			20b.	Plece of Disponentery, cre-				Dete				
			☐ Cremation 3 5 ☐ Other (Spe	Removel from						16/201	00 Sui	t.land	. bM . F	
	21	. Signature of Fu		* .										
8		DA in	140) 5	Edure	nds					_				
	21	a. Part1. Enter ti	he diseese, or co	emplications that of	aused the dea	th. Do not en	ter the mode	e of dyir	ng, such es cardia	or respiratory	arrest.		Approximate	
ner Jou	dis	mediete Cause (lease or conditio sulting in deeth)	Finel	a		Or es e conse		HES	T					
s the bunst-transit	Se if i ca Ca	quentielly list co iny, leeding to im use. Enter Unde use (Diseese or it initiated events	nditions, nmediate ortyling injury	C,	Due to (or as a consequence of):									
est.	res	sulting in death) i	ast	d	Due to (or es e consec	juence of):		2-11					
icle	Pe	art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Di	23b. Did tobacco use contributs to the cause of death?				
y Physician/M														
Completed by											erformed? available p		vaileble prior to ompletion of cause	
E										10	Yes 2 N	0 1	Yes 2 No	
Be C		Was case refer	red to medical		7.				26. Place of De	ath (Check only	one)			
5		examiner?	No	Hospital: 1 🗆									ify)	
Ë		Menner of Deati		28e. Dete	of Injury	28b. Time o	Time of 28		y et	28d. Describe	a how injury oc	curred		
atic		2 Accident	investigat	tion	m 1/1/2000 305 A			1 ☐ Yes 2 No		SUBJECT WAD ST		a) STAE	BED	
Certification:		3 Suicide 4 Homicide	6 Could no determine	of Injury - At h	ury - At home, ferm, street, factory, office c. (Specify) RESIDENCE (NA) WAY)				28f. Location (Street and Number or Rural Route Number, City or Town, State) 3333 10th NACE					
edical	29	e, Certifier (Check only one)		aminer: On the bi					me, dete end piece pinion, death occ					
completely filled in by the funeral Medical Certification: 1		o. Signature and	title of ceptitier	2.70 (11011	-		290	. Licens	se number		29d. Dete sig	ned (Month,	Dey, Year)	
1		•	()	M. /	1	M.D	0	.C.1	M.E.		Janua	ry 2,	1999	
)	30.		ess of person with	no completed caus				Str	eet, Balt	timore,				
State	31.	Date filed (Mont			egistrar's Sign	ature 4	Son	d	/					
Registrar		JAN	A 4 CAA	04	The same of the sa	10.	popor	No.						

Registrar

35M 9 4 2000 January & January

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

WILLIAM I.	ore TEMS: #23 PART I,	27 PER MEO G78	Cei	tificate	of Death		Reg. No.	UU	1500				
Physician	1. Decedent's Name (First, Middle, Las	t)	1			2. Date of D Month	eath Day	Year	3. Time of Death				
/Medical		oore				Janua	ry 11	2000	07:28 A.M				
Examiner	4a Facility Name (If not institution, give	street and number) Lot of 6801 Boo	ak Pon	a		or Location of Dea							
levenui	5. Social Security Number 6. S			If Under 1	Oxon Year If Under 24	rs. 8. Date of B	irth		orge's				
uneral irector			O Yrs.	Months D	eys Hours N	May 18	ay, 199/39	Wash.	nce (State or Foreign ry) D.C.				
	Usual Residence of Decedent	10.00											
with the Marylar a or 28a-f ahow be notified at Director	10a. State 10b. County		, Town or Lo		hea			10	d. Inside City Limits 1 ✓ Yes 2 ☐ No				
or 28a-f show be notified at Director	Maryland Prince	George's D	istric	t Heig			10a Citizon of	What Count	**				
5 8 9 7	1207 Waterford D	r.			747		10g. Citizen of What Country? United States						
	11. Marital Status	12. Was Decedent Ever in U,	5. 13.	Was Deceden	t of Hispanic Origin' Cuban, Mexican, P	(Specify Yes or N	o- 14. Rac	ce - America					
	1 ☐ Never Married 2 ☐ Merried	Armed Forces? 1 1 Yes 2 □ No If Yes, Give			No Specify:	Jerto Mican, etc.)		ck, White, e					
9 6	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specii	b: Blac	CK				
nt, the Medical I	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual C	Occupation done during most of retired)	working	16b. Kind of B	usiness/Indu	ustry				
the Man	Elementary/Secondary (0-12)	College (1-4or 5+)	me. i		ostal wor		Federa	1 Gov	overment				
Se se	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	iiddle, Maiden Sumame)						
To Be	Clarence W. Moo	re, Jr.			Mary	Wyche							
numetic e	19e. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (S	treet and Number o								
other tr	Lois Marie Eato				ord Dr.	District	_		20747				
= 5	20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐	Heilioval Itom State		natory or other		Date	20c. Location						
Injury	4 Donation 5 Other (Specify 21 Signature of Funeral Service Licen			Cremet		1/18/00	SUIT	MD.					
any	21. Signature of Puneral Service Liber	Alexander S. Pope						3					
	23a. Part1. Enter the disease, or comp shock, or heart for ure. List only	vy MUSS	Do not out	5538 N	farlboro I	Pike/Fore	stville,		20747 Approximate				
ing prysician and as the bunal-transit and as the bunal-transit and and the control of the contr	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infiltated events resulting in death) Last	a. Due to (or CHRO	RE DIS	quenca of): COHOLI quenca of):	SM								
been signed by the attending p should be detached for use as leted by Physician/Me	ie i i i i i i i i i i i i i i i i i i	0.											
ached hysi	Part II. Other eignificant conditions co	contributing to death but not resulting in the underlying ceuse given in Part I.					23b. Did tobacco use contribute to the cause of death 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ∰ Únknow						
be det						_) 100 2L NO	3 1100	on an onknown				
Completed						24a. Wa per	s an autopsy lormed?	ava	re autopsy findings ilable prior to apletion of cause eath?				
page 2						1,52	Yes 2□No	1,500	LYes 2□ No				
Be	25. Was case referred to medical examiner?	A 4				Death (Check only	one)						
	1 [™] Yes 2 No 27, Manner of Death			at 3 DOA		ng Home 5 Res			Scene				
fune	1 Natural 5-Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M			Injury et Work? 1 ☐ Yes 2 ☐ No	200. 500000	8d. Describe how injury occurred						
Certification:	3 Suicide 6 Could not be	28e. Plece of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,						
d in	4 Homicide	building, etc. (Specify)			City or 1	own, State)						
completely filled in by the funeral		rsician: To the best of my know iner: On the basis of examinat and manner stated.											
To the Funeral Director: After completely filled in by the fune Medical Certification	29b. Signature and title of certifler	20.		29c. L	icense number		29d. Date sign	ed (Month, D	Day, Year)				
	Denni	Churchen			O.C.M.E.		Jànua	ry 12	, 2000				
	30. Name end address of parson who	completed ceuse of death (Item			Street,	Baltimore							
	31. Dete filed (Month, Day, Year)	32. Registrer's Signal											

Registrar DHMH 16 Rev 6/95

ORIGINAL

SEC. S. MAR